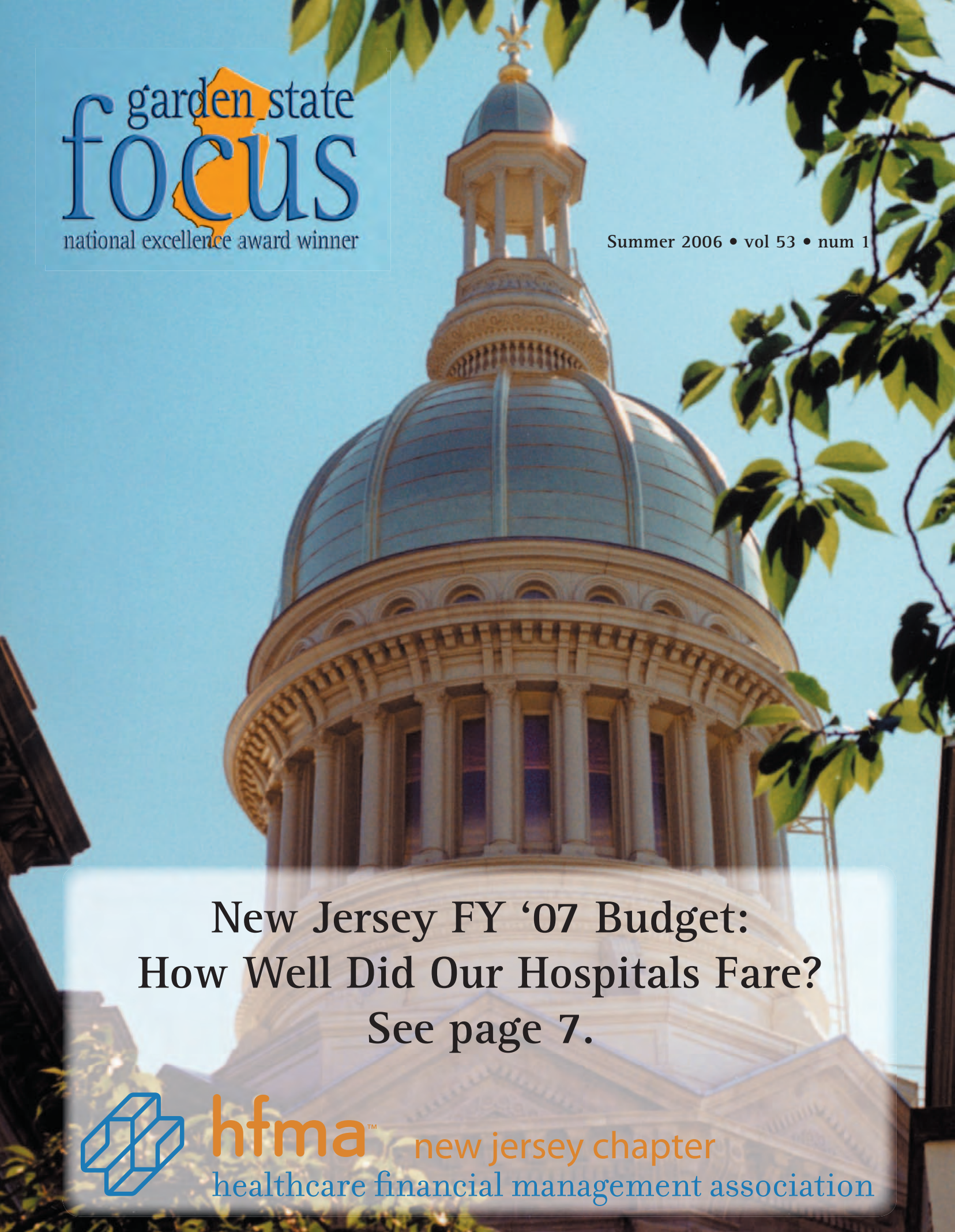

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New Jersey FY '07 Budget: How Well Did Our Hospitals Fare?

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OBJECTIVE

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

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The President's View

Dotti Lindstrom

We welcome you to the start of a 2006/2007 New Jersey HFMA Chapter Year. The Board of Directors and I are looking forward to offering our members many varied opportunities for the new year.

The Board and the Committee Chairs attended the annual Mini Leadership Retreat in June at the Seaview Resort to discuss this coming year's Chapter goals. We invited Dave Timpe, a Chapter Advancement Team (CAT) member from HFMA National, to facilitate this meeting and to share his expertise. It was agreed that the main goal for this year will be EDUCATION, EDUCATION, EDUCATION.

We are going to implement changes to the quarterly meeting presentation format to include a session on 'HOT" topics at each meeting. We will also expand the "legislative and regulatory update" portion of the meeting, giving the NJHA ample time to present and answer your questions. We are also looking into the possibility of starting the meetings at 8:30 am so that we can offer additional CPE credits for each session. Outside of the quarterly meetings, we will continue to offer separate monthly educational events and periodic certification courses. We will also be offering educational events in Southern and Northern NJ as well as in conjunction with the Philadelphia and Hudson Valley Chapters. I will have more information on this in the near future.

All HFMA Committees are in desperate need of active members. I know how hard it is to volunteer in the busy lives we lead these days. However, your own professional development, networking and career advancement can truly be enhanced by your involvement in HFMA. In addition, we will all benefit from your input. Give it a try!

The September quarterly meeting is scheduled for September 12, 2006. The Annual Institute will be held at the BORGATA HOTEL IN ATLANTIC CITY ON OCTOBER 12TH AND 13TH, 2006. The agenda is shaping up very nicely and we strongly encourage you attend to take advantage of the excellent educational and networking opportunities. If you have not attended over the last several years make the effort this year – you will not be disappointed. We have also doubled the vendor area this year so more space is available. If you have not pledged your sponsorship or want a booth, please do so soon. The brochure will be in the mail soon for all registrants and sponsors but mark your calendars now!!

Congratulations to the five new members of the HFMA Board of Directors this year; John Calandriello, Lindsey Colombo, Lisa Hartman, Jim Pender, and Dave Wiessel.

The Board also reluctantly had to say goodbye to six dedicated, hard-working Board members who donated hours of volunteer time to our Chapter; Gabby Parseghian, John Hailperin, Phil Besler, Tom Shanahan, Garry DeLeeuwerk and Doreen Stevenson. Our sincere thanks to all of you for all your time and effort.

In closing, a special thanks to our immediate Past President, John Manzi, for his leadership during the 2005/2006 year.

Dotti Lindstrom
President

From the Editor...

Elizabeth G. Litten

Dear Readers:

I am pleased to announce that this magazine has won another Helen M. Yerger Award of Excellence from the national Healthcare Financial Management Association. The award was presented on June 19, 2006 at a celebration following the Chapter Presidents Meeting and Dinner during the Annual National Institute in Orlando, Florida. The Helen M. Yerger Recognition Award was created to recognize outstanding chapter performance in several specific categories, including "Member Communications". As you know, the publications committee is comprised of volunteers who spend a great deal of time and effort throughout the year to produce this magazine. We all appreciate the fact that our publication has received this national honor, but we continue to seek ways to improve the magazine and make it as informative as possible. If you have any suggestions as to how you think we can improve the magazine (its content or format), or comments as to particular features, please feel free to email me directly at elitten@foxrothschild.com, or to email Laura Hess at njhfma@aol.com.

One example of the committee's ongoing effort to continually seek ways to improve the magazine and to respond to reader comments will be evident in the next issue. WithumSmith+Brown (WS+B) has offered to staff a regular tax and accounting advice column responding to real life industry inquiries. If you have a question involving health care reimbursement or any aspect of health care or hospital finance, please email me your question and I will forward it to WS+B for possible response in an upcoming issue. The questions can be posted anonymously, or attributed to you or your institution. Chances are good that a question posed by one of our readers is a question shared by others, and may involve an issue on which experts disagree. We hope to make this new financial Q & A column a regular feature that will provide free expert advice in a quick, easy-to-read format.

We know that this magazine only deserves the National Award of Excellence if it effectively communicates with our membership. The "FOCUS" magazine reaches more than 1,000 health care industry professionals, including New Jersey hospital administrators and a wide array of experts working with hospitals and other health care-related entities, and we will be renewing our efforts to get the magazine to key legislators and regulators affecting health care policy in New Jersey. Our loyal advertisers understand the breadth and depth of health care expertise among our readers, and we are grateful to their commitment to this magazine. Our advertisers play a significant role in enabling us to produce a magazine worthy of national recognition. Thus, as a final note, I ask that you take time to note those within the industry that advertise in this magazine and support our committee's ongoing commitment to communicating with you as effectively as possible.

Regards,

Elizabeth G. Litten, Editor

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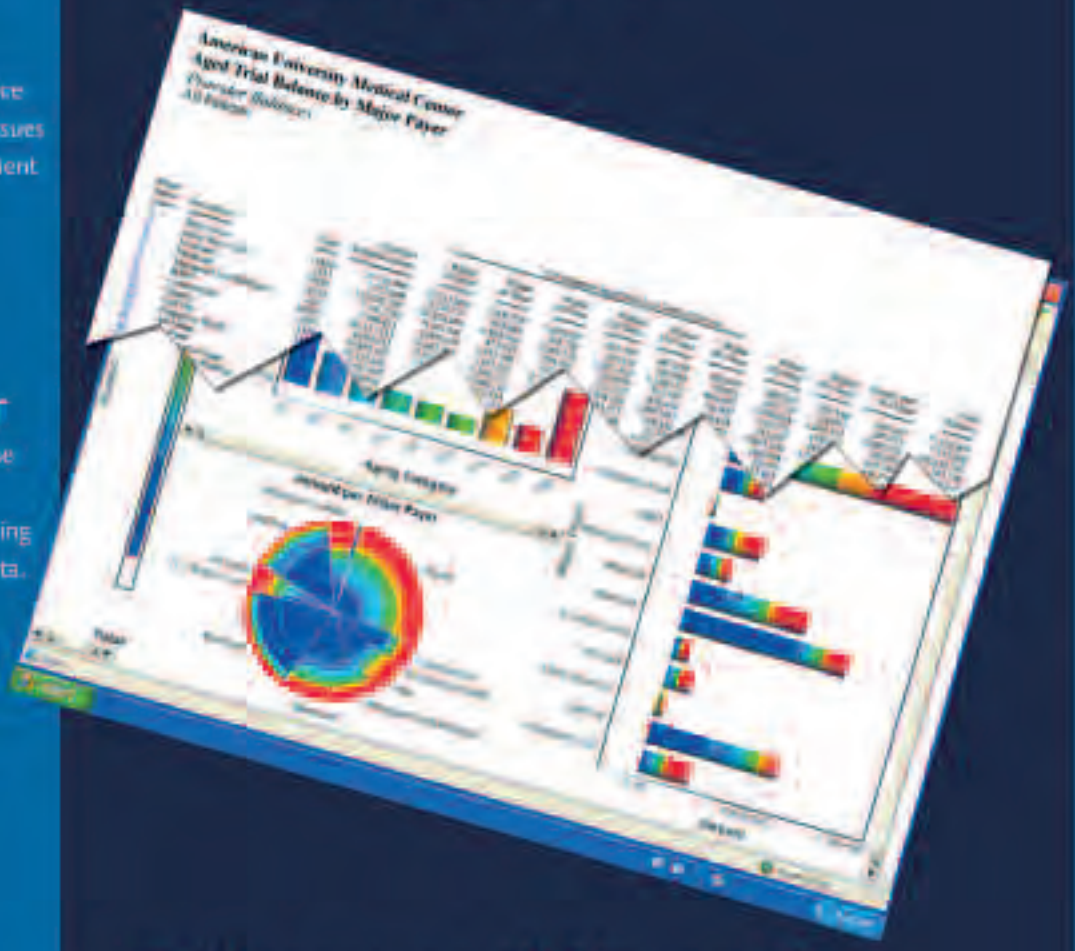

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State Budget Finally Adopted: New Jersey Hospital Association Reports

by Randy J. Minniear

Randy Minniear

One thing is for certain, this year's budget process has truly brought healthcare reform to the forefront. While our industry was successful in defeating the bed tax proposal, securing status quo funding for charity care in light of potential cuts, and avoiding additional threats to our operations through co-pays and rate reductions, additional battles lie ahead.

Governor Corzine signed into law New Jersey's Fiscal Year 2007 budget on Saturday, July 8 and concluded what proved to be a historic budget debate that lasted seven days beyond the constitutional deadline and gave witness to the first-ever shutdown in state services. In the end, the leading point of contention between the Legislature and the Administration, a penny increase in the state sales tax, was resolved by dedicating half of the revenue generated by the tax increase to direct property tax relief. While the issue of the state sales tax remained the key point of contention, the debate over a proposed hospital bed tax and adequate funding for charity care remained top-tier issues throughout the debate.

Following the Governor's budget address in March, NJHA immediately began large-scale advocacy efforts opposing a proposal to implement a 5.5 percent tax on non-Medicare hospital revenues through a $1,424 per month tax on licensed beds for acute care hospitals. The tax was expected to raise nearly $430 million, with $215 million going to the state's general fund and the other half flowing back to a select portion of the hospital community. With the Legislature and Administration facing nearly a $4 billion deficit, the industry faced an uphill battle in combating a tax proposal intended to resolve a portion of this deficit. However, NJHA and its members engaged in a united, expansive "grassroots" and "grasstops" effort with members of the Legislature, which ultimately led to the abandonment of the proposal in early June.

The defeat of the bed tax proposal remains a pivotal victory for the industry in this year's unprecedented budget debate, however, throughout the process, NJHA continued to advocate for additional priorities contained in the FY07 budget proposal.

Adequate funding for charity care was also a top priority for NJHA, with concern over the ambiguity of the Governor's original budget proposal regarding how the program would be funded and at what amount. Governor Corzine's own "Budget in Brief" document noted that the level of charity care provided by the state's hospitals was approaching $1 billion. However, it was suggested in the early stages of the budget debate that a correlation between the bed tax proposal and funding for charity care may exist. Thus, the defeat of the bed tax proposal left a delicate balance to negotiate, as the industry was reminded continuously by members of the Legislature during the final days of the debate.

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Throughout the budget review process, NJHA advocated for a rolling average of the most recent 12 quarters of documented charity care, to be supported by an adequate funding amount. As the debate entered its final days, feedback from the Legislature revealed that funding for charity care would be somewhere between $680 million and $583 million (the base amount of charity care provided in last year's budget), but it was unclear what base year formula would be utilized. In the concluding week of the debate, the Assembly introduced a budget bill of its own that contained a charity care reimbursement proposal that utilized a rolling average of 2002, 2003 and 2004 documentation with a funding level of $650 million, while the Senate position sought clarification using a 2002, 2003, 2004 and 2005 rolling average, which resulted in significant redistribution. While the rolling average would have been commensurate with NJHA's advocacy position, negotiations between the Senate, Assembly and the Administration produced a different solution.

Ultimately, the agreement struck for charity care in the FY07 budget will provide the same funding and distribution formula as used in FY06, that is, $583 million in funding utilizing the 2002 base year for documentation. The funding amount was to be supplemented by $75.4 million in supplemental funding and direct Hospital Assistance Grants to selected hospitals, however, the Governor determined that this amount will be reduced by 10 percent through his line item veto of the bill. Charity care funding will continue to be derived from previous revenue sources, such as funding from the tobacco tax, funding from the increased assessment on HMO premiums, funding from the ambulatory care center assessment, funding from the cosmetic surgery tax and additional general fund revenues.

Beyond the resolution to charity care funding and the demise of the bed tax, the industry achieved victories on several other fronts addressed in the FY07 budget. NJHA was able to obtain budget language that will implement cuts to partial hospitalization services through an inclusive regulatory process in which the industry will be afforded the opportunity to ensure these reductions are achieved in an appropriate manner that is as least onerous as possible. As originally proposed, the Governor's budget planned to implement $20 million in annualized cuts to these critical services through expansive rate reductions.

NJHA's efforts were also successful in eliminating a proposal to implement new co-pays on Medicaid services. As originally proposed, hospitals would have been forced to collect co-pays from Medicaid recipients on inappropriate use of emergency room services.

Ultimately, the agreement struck for charity care in the FY07 budget will provide the same funding and distribution formula as used in FY06, that is, $583 million in funding utilizing the 2002 base year for documentation.

One thing is for certain, this year's budget process has truly brought healthcare reform to the forefront. While our industry was successful in defeating the bed tax proposal, securing status quo funding for charity care in light of potential cuts, and avoiding additional threats to our operations through co-pays and rate reductions, additional battles lie ahead. Already, the legislature has taken up reform issues that mirror efforts pursued in other states, such as employer mandates on minimum healthcare expenditures and buy in programs for State funded healthcare programs for the working poor.

NJHA looks forward to being an active participant in future dialogue regarding healthcare reform initiatives and would like to express its appreciation to the Governor, the Legislature and legislative leadership for recognizing the importance of charity care funding and for responding to NJHA's budgetary concerns, specifically the elimination of the proposed bed tax.

About the Author

Randy has managed NJHA's state legislative advocacy efforts since 2004 after having represented the Chemistry Council of New Jersey as Director of Government Affairs. Prior to working in government relations, Randy served as Chief of Staff to Senate President John O. Bennett.

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Real-Time Solutions For Addressing Unreimbursed Health Care Costs For The Treatment Of Undocumented Aliens

James A. Robertson

Loretta M. Orlando

by James A. Robertson, Esq., Loretta M. Orlando, Esq. and Audrey Murphy, Esq., R.N.

INTRODUCTION

It comes as no surprise that hospitals are increasingly shouldering the economic burden of providing care to undocumented aliens. As of the year 2000, there were 7 million undocumented aliens in the United States and 221,000 undocumented aliens in New Jersey. These individuals are in the United States illegally, because they entered the country without legal permission or they failed to leave when the permission expired. Undocumented aliens without insurance cost New Jersey hospitals over $200 million dollars a year.

Many illegal aliens in New Jersey are employed in manual labor jobs such as landscaping, construction and painting. Frequently, the illegal alien suffers an injury on the job and seeks emergency medical treatment at a local hospital. The injuries can range from the less serious sprains, or lacerations which may require stitches, to more serious broken bones which require orthopedic surgery, to severe head trauma injuries causing brain hemorrhaging and requiring complicated, life-saving surgery. Sometimes a hospital will be faced with a competent adult patient who refuses to provide information and sometimes a patient who becomes incapacitated by virtue of the injury they sustained. In all cases, the hospital experiences a financial strain because the services being provided are not being paid for by the patient (because usually the patient is indigent) or by a third-party payer (because the patient does not have health insurance and does not, or cannot, qualify for any governmental medical assistance).

As a result of their illegal status, the patients generally do not qualify for federal benefit programs (*e.g.,* Medicare or Medicaid)[1]. In addition, illegal aliens are ineligible for the New Jersey charity care subsidy program. Without charity care qualification, illegal aliens will continue to add to the already $1.2 billion New Jersey hospitals write-off every year in bad debts.[2]

This article will outline certain steps that a hospital could take to place it in the best position possible to receive some form of reimbursement when a patient, whom the hospital suspects may be an illegal alien, seeks hospital medical care. At the outset, it is helpful to set the stage by discussing a hospital's duty to treat illegal aliens.

A. THE DUTY TO TREAT ILLEGAL ALIENS WHEN THEY PRESENT AT THE EMERGENCY ROOM

Very often, illegal aliens come to the emergency room to receive medical care when needed and they cannot be turned away by the hospital because of the Emergency Medical Treatment and Labor Act, 42 *U.S.C.A.* §1395dd(e)(2) ("EMTALA") and the New Jersey law that prohibits hospitals from refusing to treat the patients with emergencies.

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1. Hospital's EMTALA Obligations

EMTALA requires that a hospital's emergency room provide a medical screening evaluation to all patients who seek care to determine if an emergency medical condition exists. If an emergency medical condition[3] is present, the hospital must provide treatment to stabilize[4] the patient's medical condition, or to make an appropriate transfer to another facility. A hospital is liable under EMTALA if:

(1) The hospital does not conduct a medical screening evaluation; or

(2) After the evaluation, the hospital transfers or discharges a patient in an unstable medical condition.

A patient may request a transfer in writing or the hospital may transfer so long as the benefit of transfer outweighs the risk. This is known as an "appropriate transfer" and requires that transport support be provided as dictated by other statutes and regulations, the receiving facility agree to the transfer, and the medical records be provided. Labor is considered an emergency when a pregnant woman is having contractions and if there is inadequate time to transfer prior to delivery or the transfer is a threat to the mother or child.

EMTALA provides for a private right of action for an individual who has been harmed as a direct result of a violation and for civil monetary penalties in the amount of $50,000 per violation against a hospital. The intent of EMTALA is to prevent patient dumping or a transfer to another facility when a patient is not stable, and therefore, in a condition where he or she could be irreparably harmed.

Thus, under EMTALA, a hospital has the obligation to provide every patient, illegal aliens included, with a medical screening and if an emergency medical condition exists to stabilize the patient before transferring the patient to another facility. Not surprisingly, when no form of payment is available, it is difficult to get another facility to accept a transfer.

2. A New Jersey Hospital's Obligation to Not Turn Away Any Patient Because of Ability to Pay

New Jersey also has a statute, found at *N.J.S.A.* 26:2H-18.64, which provides that "No hospital shall deny any admission or appropriate service to a patient on the basis of that patient's ability to pay or source of payment." A hospital that violates this statute is liable for a

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civil penalty of $10,000 for each violation. In 2001, the Legislature amended *N.J.S.A.* 26:2H-18.63 to permit hospitals to secure a source of payment for non-emergency services for patients who do not otherwise qualify for any source of governmental assistance. The section of that statute, *N.J.S.A.* 26:2H-18.63(e), now states:

> A person who is seeking health care services at a hospital as a patient for a non-emergency or elective procedure who does not furnish proof of health insurance coverage for the services or eligibility for charity care or reduced charge charity care in accordance with the provisions of section 10 of P.L.1992, c. 160 (C. 26:2H-18.60), or for any other program of benefits funded by the State, shall be required to provide sworn financial information sufficient to determine eligibility for any such program of benefits. Notwithstanding any other provision of law to the contrary, if the person does not provide the required financial information or the hospital determines that the person is ineligible for any of the aforementioned benefits, **the hospital shall be entitled to conclude an arrangement with the person, or an individual acting on the person's behalf, to receive payment from or on behalf of that person as a condition of the provision of health care services to that person.**
> For the purposes of this subsection, "non-emergency or elective procedure" means a procedure to treat a condition that is not an "emergency" as defined in *N.J.A.C.* 8:38-1.2.

Thus, if an illegal alien presents at the hospital for non-emergency or elective treatment, and the illegal alien is not covered by commercial health insurance, does not qualify for any government medical assistance program (including charity care), or does not provide the requisite financial information for the hospital to make the determination of whether the illegal alien qualifies for governmental medical assistance (including charity care), the hospital may decline to provide medical services to that person until a payment arrangement is entered into with the patient or another person acting on the patient's behalf. Certainly, a payment plan, in accordance with *N.J.S.A.* 26:2H-18.63(e), could and should be negotiated with the patient or the patient's family in non-emergency situations. The New Jersey Hospital Association's billing and collection guidelines should also be consulted when attempting to collect on a bill for an uninsured patient.[5] This statute, however, only applies in non-emergent situations. In emergency situations, the obligations of EMTALA and *N.J.S.A.* 26:2H-18.64 govern.

B. THE GOVERNMENT'S RESPONSE TO THE ILLEGAL ALIEN CRISIS

There have been several attempts by the federal and state governments to address the growing health care crisis caused by uncompensated health care costs associated with care to illegal aliens. For example, in 2004, a bill was proposed which focused on the employers of these illegal individuals. H.R. 3722 (Rohrabacher R-CA) required that if a hospital could ascertain who the employer was, the employer should be held liable for the medical costs. The bill was intended to serve as a deterrent to the hiring of illegal aliens and to prevent the exploitation of illegal aliens by promoting safe work conditions. This bill also prohibited non-emergency treatment of illegal aliens, and provided for notification to the Department of Homeland Security. However, this bill did not pass.[6]

A bill proposed in the New Jersey Assembly, A-993 (Moran, Connors) is antithetical to the federal bill proposed by Representative Rohrabacher, and would prohibit an illegal alien from qualifying for worker's compensation and temporary disability. The effect of this bill would have been to insulate employers from liability for workplace injuries; however the bill died in committee.

On December 8, 2003, the President signed into law the Medicare Prescription Drug Improvement and Modernization Act of 2003 (Pub. L. 108-173). Section 1011 of the Act addresses reimbursement of emergency health services mandated under EMTALA for undocumented aliens and other specified aliens. Section 1011 provides for an appropriation of $250 million per year for years 2005-2008. Two-thirds of the funds are divided between the fifty states based on the state's percentage of undocumented aliens, and the remaining third is divided among the six states with the largest number of alien apprehensions. New Jersey's allotment is a meager $5.27 million a year. Any hospital or provider wishing to participate may do so by enrolling at http://www.cms.hhs.gov/providers/section1011. Once registered, hospitals can submit the claims directly on a retrospective basis. Payment will be made directly to hospitals, certain physicians, and ambulance providers. CMS will determine payment amounts based on Medicare rules, and all payments are aggregated on a state level and are paid on a quarterly basis. This gives hospitals potential reimbursement for a portion of the emergency care rendered to illegal aliens. However, with only $5.27 million available for the whole state, hospitals are well advised not to expect too much from this fund.

More recently, there has been a national movement to regulate immigration into the United States. Currently, there are two federal bills pending, one in the Senate and one in Congress, which take dramatically different ap-

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proaches to addressing this multi-faceted problem. The first bill, S-2611, entitled the "Comprehensive Immigration Reform Act of 2006," has already passed the Senate. Highlights of S-2611 include:

1. A path to lawful permanent residency for those immigrants here for five years or longer, so long as they pay fines, fees, back taxes and learn English;
2. Those here for two to five years must go to a port of entry at the border to complete an application;
3. Those here for less than two years will be deported;
4. Establish a "guest worker" program for farm workers;
5. Construction of a fence along a portion of the border;
6. Hiring more Border Control agents and building additional detention facilities; and
7. Require employers to verify an employee's status by using an electronic system.

The second bill, HR-4437, passed in the House and is much more punitive in nature with more draconian penalties for violation of the immigration laws. Under the House Bill, there are no pathways to lawful permanent residency for those already in the United States. Highlights of this bill include:

1. Illegal presence in this country will be made a felony, with increased penalties for those individuals;
2. Makes it a felony for anyone to assist or aid an individual entering or remaining in this country;
3. Increases fines for the employers of illegal aliens and adds prison sentences to the penalties;
4. Mandatory detention of all non-Mexican immigrants;
5. Mandatory prison sentence for those found smuggling aliens or those who re-enter after deportation; and
6. Construction of a fence along a portion of the border.

At present, neither bill addresses health care reimbursement issues for care given to illegal aliens. Neither of these two bills has become law, and at the time this article was authored, these were the current versions; however lawmaking is a dynamic process and these bills will most likely be modified before they are eventually passed and become law.

C. PROCESS TO BE FOLLOWED FOR SEEKING PAYMENT FOR SERVICES PROVIDED TO ILLEGAL ALIENS

Given the increasing frequency of the reimbursement issues posed by hospital care given to illegal aliens and the lack of legislative action addressing these reimbursement issues, hospitals may have to think outside the box in seeking payment for health care services to illegal aliens. At the very least, the following practical guidelines could be followed to put hospitals in the best position to protect their right to receive payment for services provided to illegal aliens absent specific legislation.

1. Step One: Determine If The Patient Qualifies For Emergency Medicaid

Because New Jersey does not offer reimbursement akin to California's Medi-Cal benefits, illegal aliens receive no form of federal or state health coverage whatsoever. Legal aliens who do not qualify for Medicaid (because they entered the country after August 22, 1996[7] and are excluded from federal public benefits for five years[8]) may be eligible for New Jersey Medicaid's Medical Emergency Payment Program. This can be done through the county social service board after the care is given. This program only exists for legal aliens, so it is imperative for the hospital to determine who is legal and who is not by requesting documentation. Although the hospital has no legal duty to inquire into immigration status, the hospital may potentially lose this payment source if the hospital cannot refer those individuals to this resource. A hospital could also implement outreach into the community, which would foster awareness in the immigrant community that they must share this information with the hospital. It should be emphasized that disclosing that a patient is undocumented is not reportable to United States Immigration and Customs Enforcement ("ICE") and the patient will not be deported for applying for Emergency Medicaid, revealing their employer, or the place where the accident occurred. Hospitals should make clear that by disclosing this information, they will not seek punitive action against the individual; however, hospitals could also make clear that they will hold those potentially responsible parties accountable for the patient's medical bill.

2. Step Two: Determine Whether The Injury Occurred During The Patient's Course Of Employment, And If So, Notify The Employer Of The Hospital's Intent To Pursue Payment

For those patients not eligible for Medicaid, a hospital should ascertain information about the patient's employer if it is suspected that the patient was injured on the job. If an individual has sustained an injury while at work, the hospital may be able to receive reimbursement from the employer's worker's compensation policy. An undocumented alien can pursue a worker's compensation claim, because worker's compensation laws define employees as

"natural persons," and therefore, citizenship is irrelevant. It should be expected, however, that the patient will be reluctant to cooperate for fear of deportation. Likewise, the employer will either not be willing to reveal whether the patient is an employee or may reveal a false name for fear of being sanctioned by the worker's compensation program.

The emergency room staff should attempt to ascertain the correct identity of the employee/patient and the employer. Once the employer's name is obtained, the name of the employer's worker's compensation carrier can be accessed through the New Jersey Compensation Rating and Inspection Bureau web site found at http://www.njcrib.com. This site allows an individual to search for the worker's compensation carrier, so long as the name of the employer is known. Even if the employer is uninsured, New Jersey has set aside funds for those injured and whose employers do not carry worker's compensation. This is known as the Uninsured Employers Fund.[9] The fact that the hospital has the name of the employer's worker's compensation carrier could persuade the employer to simply pay the patient's medical bill instead of submitting the claim to the worker's compensation carrier.

If the claim has to be pursued, the hospital could then provide assistance to the patient in completing a worker's compensation claim application. The hospital could also obtain from the patient an assignment of his or her right to pursue a worker's compensation claim or other legal claims. Obtaining an assignment would put the hospital in the strongest position to pursue payment. The assignment should include an assignment of the right to bring suit on the patient's behalf to collect from the worker's compensation program or from other sources. The language of the assignment (which should be translated into the patient's native language) could state that the patient assigns the following rights to the hospital:

1. To make, file and settle proofs of claim under any insurance policy or for compensation or benefits of any character and to make, file and settle any claims for governmental assistance that may be available to the patient as a result of the services the patient received at (hospital).
2. To take all lawful steps to recover, collect and receive any amounts of money now and hereafter owing or payable to the patient in relation to the injuries incurred which brought the patient to (hospital) on (date), including but not limited to pursuing a worker's compensation claim, Personal Injury Protection ("PIP") claim, claims against the patient's employer, owner of property where the patient's injury occurred, governmental entity or the patient's sponsor who sponsored the patient upon the patient's admission into the United States, and to compromise, settle or adjust claims for the patient and on the patient's behalf, and to execute releases or other sufficient discharges for the patient;
3. To sue and settle suits of any kind in the patient's name, for the patient's benefit or for (hospital's) benefit, including specifically the power to sue to compel payment of the hospital bill in a worker's compensation action, PIP action, lawsuit against the patient's employer, owner of property where the patient's injury occurred, governmental entity or the patient's sponsor who sponsored the patient upon the patient's admission into the United States, and to compel acceptance of and reliance upon this assignment and to seek damages, including punitive damages in relation to the injuries which brought the patient to (hospital) on (date).

It should be noted that, even absent an assignment, a hospital may have an argument that sufficient standing exists to pursue a claim or bring a lawsuit on the patient's behalf seek-

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ing payment. In New Jersey, the hospital might be able to assert standing to sue to collect on its hospital bill under the well-established case law imbuing hospitals with the status of a quasi-public trust. Under this quasi-public trust doctrine, a hospital operates "for the benefit of the public" and "in aid of service to the public." *Greisman v. Newcomb Hospital,* 40 N.J. 389, 403-404 (1963). A hospital could invoke the quasi-public trust doctrine to establish standing to pursue collection of its bill or a suit against the patient's employer, even in the absence of and assignment from the patient. The rationale would be that the hospital has an obligation to the public to seek any and all sources of payment to protect the charitable assets it is entrusted by the public to oversee. However, this theory has not been tested in court.

In any event, and even if the patient does not provide an assignment to the hospital, a letter could be sent to the employer requesting information on its worker's compensation carrier to pursue the claim. Care should be taken to protect the confidentiality of the illegal alien's Protected Health Information ("PHI") under HIPAA. Even the mere fact that the hospital treated the patient in its emergency room is PHI under HIPAA and unless an exception applies, the hospital cannot disclose to the employer that it treated an employee. There is an exception under HIPAA for certain disclosures in connection with a worker's compensation claim. This exception states that:

> "A covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault." 45 *C.F.R.* §164.512(l).

However, it is not entirely clear from this language whether the circumstances we are discussing here fit under that exception because there is nothing to suggest that the hospital's disclosure of PHI to the patient's employer is "necessary to comply with laws relating to workers' compensation."

Therefore, the safer approach is to send a letter to the employer which indicates that the hospital treated one of its employees (but do not identify the employee by name) on a specific date for a work-related injury and that the hospital understands that "XYZ" Insurance Company is the employer's worker's compensation carrier. The employer should be told that the hospital would like to submit a claim to the carrier and is seeking confirmation that "XYZ" Company is its carrier. Also, the hospital should reference the policy number in the letter. We believe that this letter will have the intended effect of putting the employer on notice of the hospital's intent to pursue payment, which will then prompt the employer to call the hospital so that an arrangement can be worked out or a claim can be submitted. The letter should not threaten to do anything if the employer does not respond. It should simply ask the employer to confirm the information the hospital was able to ascertain. If the employer does not respond, the hospital should notify the Division of Worker's Compensation and the Compensation Rating and Inspection Bureau and inquire about next steps.

It may be time for hospitals to become more aggressive in pursuing reimbursement for services provided to illegal aliens.

3. Step Three: Determine Whether The Patient Is Incapacitated, And If So, Pursue The Appointment Of A Legal Guardian And Protect The Hospital's Right To Receive Payment

If a patient is mentally incapacitated (i.e., two physicians determine that in their professional medical opinion, the patient is unable to govern himself or manage his own affairs),[10] the appointment of a guardian should be pursued. The hospital could have the court incorporate a provision in the order appointing the guardian which requires the legal guardian to do two things: (1) pursue a worker's compensation case or other potential avenues of payment; and (2) that the hospital's bill have priority and be paid from any potential recovery or settlement before any other obligations are paid. This would be the case if the patient was injured at work or not.

This is a proven strategy. A young man, who was in the country illegally, was admitted to a hospital after sustaining a severe head injury from a fall following his excessive consumption of alcohol at a social party hosted by his employer. The hospital pursued the appointment of a legal guardian because he was in a persistent vegetative state and the patient's family refused to consent to the patient's discharge and transfer to a long-term care facility. Treating the matter as a discharge and transfer case, the Chancery Court ordered that the patient be discharged from the hospital and transferred to a charity care hospital in his home country of El Salvador, a decision that was unanimously affirmed by the New Jersey Supreme Court.

Particularly relevant to the present analysis, during the course of the guardianship case, the hospital discovered that the patient's family hired a lawyer to pursue a worker's compensation case, claiming that the patient was in-

jured on the job, and a separate lawsuit under New Jersey's Dram Shop law, claiming liability against the patient's employer for having served him excessive amounts of alcohol. Upon discovering these lawsuits, the hospital insisted that an indemnification provision be included in the final judgment appointing a guardian which entitled the hospital and the nursing home, to which the patient had been transferred on an interim basis, to be paid first out of any settlement or judgment proceeds from either lawsuit. This provision included the payment of attorney's fees, costs and expenses incurred in bringing the action.

The patient's worker's compensation case was dismissed by the Appellate Division in an unpublished decision that found that his accident did not occur during the course of employment, but rather, during a social function which is a specific exception to liability under the worker's compensation statute.[11] However, the Dram Shop lawsuit settled and the employer's insurance carrier paid approximately $3 million in the settlement. The hospital agreed to accept and was paid nearly $1 million on a total hospital bill of $1.26 million.

Fortunately, in this matter, the patient's family pursued the various lawsuits independent of the hospital's involvement. However, because the hospital had been proactive in the guardianship process, the hospital was able to protect its right to payment for its bill. The valuable lesson to be learned is that it is important for a hospital to be proactive in cases involving patient incapacitation because by pursuing a guardianship action, the hospital can better control the outcome of the case by having a guardian appointed who can pursue reimbursement options and protect the hospital's right to payment.

4. Step Four: Identify Other Potentially Responsible Parties

As the foregoing discussion highlights, there are several potentially responsible parties who could be liable for payment of the hospital's bill. The proper responsible party will depend, in part, on what the patient was doing when the injury occurred, and/or where the injury occurred. A hospital may want to put some or all of the potentially responsible parties on notice of a potential claim. Putting one party on notice of potential responsibility for payment of the patient's medical bill is not mutually exclusive of putting another party on notice. In addition to pursuing the patient's employer under a worker's compensation policy, if the injuries were suffered during the course of employment, an injured patient who is an illegal alien or the hospital, on the patient's behalf, could pursue a claim against:

(i) the patient's employer under additional theories such as negligence, or Dram Shop liability depending on the particular facts surrounding the injury. Such a claim could be covered by other policies of insurance such as the employer's general liability policy;

(ii) the patient's Personal Injury Protection ("PIP") automobile insurance carrier, or his/her employer's PIP carrier if the injury was caused by an automobile accident, including an accident between two cars or a pedestrian or bicyclist struck by a car. If the individual does not have auto insurance but is involved in an accident with a car, a claim could be made with the Uninsured/ Underinsured Motorist Fund ("UIM");

(iii) the owner of the house, property or building where the injury occurred. In such a case, the homeowner's policy or general liability policies of the property owner or landlord may stand behind the homeowner or property owner; and

(iv) a governmental entity, such as a city, municipality, or county if the injury occurred on governmental property.

Finally, it may be possible to pursue payment from the alien's sponsor. When an alien enters this country legally (*i.e.,* on an appropriate visa), he or she must have a sponsor, or an individual who states that they will prevent the alien from becoming a public charge. A sponsor must submit an affidavit of support for the alien, stating that the sponsor will pay for certain public services.

Although for decades the federal government has required that affidavits of support be signed by sponsors, there has not been an instance of the government actually using the affidavit to collect a debt owed by the legal alien. Two cases are somewhat instructive and could be used to develop the argument. In a recent divorce case, an Indiana federal district court held that the sponsor could be held financially liable in a divorce context for the promise of support that the sponsor makes, finding that the alien can sue the sponsor directly for the promise of support. *Stump v. Stump,* LEXIS 26022 (D. Ind. 2005). In another lawsuit, two California citizens sued the county and a hospital, attempting to compel the county to collect medical costs from a legal alien's sponsor.[12] The plaintiffs believed that the hospital and county had made no effort to collect, and therefore, their inaction cost taxpayers in unreimbursed medical costs. The Friends of Immigration Law Enforcement, who were actively involved in the case, stated that they did not envision the hospital's suing the sponsor, but that it believed that the hospital should take the first step in sending a bill. The court

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dismissed the suit finding that the hospital had no legal obligation to inquire about immigration status. The Court did note, however, that a hospital is not prohibited from inquiring about a patient's alien status and pursuing the sponsor for payment. Thus, a hospital is free to notify the sponsors of aliens and could pursue payment of hospital bills from the sponsors.

CONCLUSION

It may be time for hospitals to become more aggressive in pursuing reimbursement for services provided to illegal aliens. A concerted effort should be made by hospitals to address this consistently and in a non-punitive manner in an effort to encourage cooperation by the undocumented aliens to share truthful information about his or her immigration status, employer, and the circumstances surrounding his or her injuries. In sum, hospitals could follow the following four-step process to maximize the potential to receive reimbursement for what would otherwise be uncompensated care given to illegal aliens:

1. Determine if the Patient qualifies for emergency Medicaid.
2. If the injury occurred during the course of employment, obtain the patient's employer information and a patient assignment of the right to pursue a claim or suit. The employer should then be notified of the hospitals' intent to follow through on a worker's compensation claim.
3. Pursue appointment of a legal guardian if the patient is incapacitated and obtain specific court relief to require the guardian to pursue the various legal claims the patient may have and to obligate the patient's estate to pay the hospital bill first out of the proceeds of any recovery or settlement.
4. Identify other potentially responsible parties, including the homeowner, landlord or governmental entity that owns the property where the injury occurred, and/or the alien's sponsor into the United States, and place these parties on notice of a claim for payment.

Following this process will enable hospitals to pursue payment even in a situation where many hospitals perceive there are no avenues for reimbursement.

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1 Illegal aliens are not the only individuals unable to obtain federal benefits. Under the Personal Responsibility and Work Opportunities and Reconciliation Act ("PRWORA"), other individuals not eligible include non-immigrants (those with student visas and foreign visas), those legal aliens applying for asylum, family unity, adjustment status, or for whom deportation is suspended or withheld. Personal Responsibility and Work Opportunities Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105: Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251.

2 Individual State Medicaid programs may choose to cover certain populations of undocumented aliens. In California, for example, the Medicaid program covers pregnant women, emergencies, nursing home care, dialysis and treatment for breast and cervical cancer. In order to qualify, and individual must be elderly, disabled, pregnant, a child or a parent. This is referred to as "Restricted Medi-Cal."

3 An "Emergency Medical Condition" is a medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

(i) placing the health of an individual (or with respect to a pregnant woman an unborn child) in serious jeopardy;
(ii) serious impairment of bodily function; or
(iii) serious dysfunction of a bodily organ. 42 *U.S.C.A.* §1395dd (e)(1).

4 The phrase "to stabilize" means "… to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or to delivery [of the baby]." 42 *U.S.C.A.* §1395dd (e)(3).

5 These guidelines, called *Approved Statement of Principles and Guidelines for Hospital Billing and Collection Practices* can be found at www.njha.com.

6 Another federal bill, H.R. 2848 (Kolbe-AZ) has been proposed which would provide for federal custody and federal payment for costs of emergency ambulance and medical services for aliens attempting to enter the United States. The Border States (California, Arizona, New Mexico, and Texas) pay the health care costs for individuals injured while attempting to cross the border. The federal government does not pay because the illegal aliens are not in federal custody.

7 This is the date that welfare reform went into effect. Those already in the United States legally were "grandfathered" in under the previous more lenient rules about Medicaid eligibility.

8 Although excluded from federal Medicaid funds, states may, with their own funds, choose to cover certain groups of legal aliens before the 5 year benchmark is reached (i.e., pregnant women, children, and the disabled)

9 For more information on New Jersey Worker's Compensation programs, view their website found at http://www.nj.gov/labor/wc

10 New Jersey Court Rule 4:86-2.

11 *Orlando Flores v. The Palisadium Daewon,* Docket No. A-6738-99T5 (April 17, 2001).

12 *Anderson v. Los Angeles Department of Health Services,* BS086042 (CA Sup. Ct., July 19, 2002), available at http://www.filus.com

Rapid Diagnostic HIV Testing

by Sindy M. Paul, M.D., M.P.H., Eugene Martin, Ph.D., and Evan Cadoff, M.D.

Sindy M. Paul

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Introduction

New Jersey is a high prevalence state ranking 5th in the United States in cumulative reported AIDS cases, third in cumulative reported pediatric AIDS cases and has the largest proportion of women among its cumulative reported AIDS cases.[1] At the end of 2004, 32,746 persons were reported living with HIV or AIDS in New Jersey.[2]

Antibody testing to diagnose HIV was introduced in 1985.[3] The standard laboratory testing protocol for HIV requires obtaining a specimen and sending it to a licensed laboratory for testing. The patient needs to return for a second visit to receive test results, and many patients do not return for their test results. The time required for testing is typically two days to two weeks. The lag time between obtaining a specimen and providing results is a time of high anxiety and significant stress for many of these patients.

There have been many changes in testing since the development of the original enzyme immunoassays (EIA) and Western blot. At the forefront of recent advances are rapid diagnostic HIV tests.

Rapid HIV testing can be integrated into daily practice. This testing has clinical applications for: 1) assisting in the diagnosis and counseling of persons with HIV disease; 2) reducing the risk of occupational and non-occupational HIV transmission; and 3) reducing the risk of vertical HIV transmission, particularly for women in labor with unknown HIV status.[6-8]

Rapid point-of-care diagnostic HIV tests offer the advantage that people do not need to return to obtain their test results. More people know their HIV status, and if infected, can be referred for treatment, prevention programs, and social services much more rapidly. People who know they are infected with HIV are more likely to practice risk-reduction, especially, if a brief behavioral intervention is conducted at the patient visit.[7]

Rapid Diagnostic HIV Tests

Rapid HIV tests to detect HIV antibody, are designed to allow health care providers to supply definitive negative and preliminary positive results in as little as 10 minutes at the time of the patient visit. In comparison, traditional enzyme immunoassays (EIAs) require specimen transmittal to a laboratory, which usually batches specimens for processing, and requires significant operator expertise. These requirements often delay results for as much as one to two weeks.[8] Rapid HIV tests are comparable in sensitivity and specificity to traditional EIAs, but can be performed by testing personnel with limited technical expertise in as little as 10 minutes.

The Federal Food and Drug Administration (FDA) has approved four rapid HIV tests and they are currently available for use in the United States, two of which are point-of-care tests. The point-of-care rapid tests are OraQuick® Advance HIV-1/HIV-2 (OraSure Technologies, Bethlehem, PA) and Uni-Gold™ Recombigen® (Trinity Biotech PLC, Wicklow, Ireland). Moderately complex rapid HIV tests that need to be conducted in a laboratory include: Reveal™ G2 Rapid HIV-1 Antibody Test (MedMira Laboratories, Halifax, Nova Scotia) and Multispot HIV-1/HIV-2 (BioRad Laboratories, Hercules CA).

A negative result requires no further laboratory testing. A positive result requires confirmation with a Western blot test. Performance results of four commercial rapid HIV tests using whole blood yielded sensitivities ranging from 95.3% to 100% and specificities ranging from 96.7% to 100%.

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The sensitivity and specificity of most rapid assays are comparable to those of non-rapid EIAs (100% sensitivities and >99% specificities). In low prevalence settings, the negative predictive value of a single rapid HIV test is high. Hence, a negative rapid HIV test does not require further testing and negative results with result-specific counseling can be provided to most persons at the initial visit. However, because the positive predictive value varies with prevalence of HIV infection in the population tested, the positive predictive value will be low in populations with low prevelance.[9] This phenomenon has led to a testing strategy that requires a reactive EIA or rapid HIV test to be confirmed by a supplemental test.[10] In studies conducted outside the United States, specific combinations of two or more different rapid HIV assays have provided results as reliable as those from the EIA/western blot combination that is currently in widespread use.[11] In the United States, current recommendations require confirmatory testing to be conducted utilizing a Western blot or an immunofluoresence assay.[12]

The ease of performing some rapid HIV tests have led their manufacturers to seek and be granted waived test status under the federal Clinical Laboratory Improvement Amendments (CLIA). CLIA waived status allow testing facilities to offer HIV testing with less restrictive regulatory requirements. However, in order to ensure a high quality testing environment, the FDA has limited the test to registered laboratories, and requires that the facility institute a quality assurance program. The guidelines from the Centers for Disease Control and Prevention (CDC) recommend participation in a proficiency testing program.[8]

Diagnosis of Patients Using A Rapid HIV Diagnostic Test

The CDC currently recommends that all providers integrate HIV counseling and testing into routine practice.[7] The use of rapid HIV tests in clinical care settings can substantially improve the delivery of HIV counseling and testing (CT) services because patients can receive their results the same day. A major issue in the United States has been patients who have HIV counseling and testing and who do not return to receive their test results and post-test counseling. The CDC reported that of 2.5 million persons tested in 1995, 25% of those testing positive and 33% of those testing negative did not receive their test results. CDC calculated that a total of 697,495 more persons nationwide would have learned their HIV status if rapid HIV testing was used.[13]

Clinicians frequently have patients to whom HIV testing should be offered. These include:

- pregnant women,
- persons with a possible acute occupational exposure,
- patients with a known sexual or needle-sharing exposure to the virus,
- patients in settings serving populations at increased behavioral or clinical risk,
- patients in areas in which the prevalence of HIV disease is 1% or greater,
- patients with a self-reported HIV risk behavior, such as injection drug use, men who have sex with men, and unprotected vaginal or anal intercourse with more than one sexual partner or with a partner who may be infected with HIV,
- patients who specifically request an HIV test,
- patients with clinical signs or symptoms of HIV disease (e.g., fever, illness of unknown origin, oral thrush, unexplained lymphadenopathy with or without weight loss, or psoriasis), and
- patients with a diagnosis suggesting increased risk of HIV disease such as opportunistic infections, tuberculosis, cervical or anal cancer, Kaposi's sarcoma, lymphoma, recurrent pneumonia or bacteremia, hepatitis B, hepatitis C, or a sexually transmitted disease should be offered counseling and testing.[8,9]

Integration of rapid HIV testing in daily practice would allow prompt diagnosis of patients with HIV disease. These patients can then be referred to a provider with experience and expertise treating HIV patients. In addition, these patients can be referred for prevention and social services.

Interpretation of Rapid HIV Test Results

Interpretation of rapid HIV tests is the same as other HIV screening tests. A negative result from a single test is interpreted as being negative. However, as with other HIV screening tests, if a person may have been exposed to HIV within three months of the test, a repeat test at a later time is recommended. A positive (or reactive) result is considered to be a preliminary positive test result. This must be confirmed using a Western blot or an immunofluoresence assay (IFA). This confirmatory testing should be done as soon as possible. If the rapid HIV test is a preliminary positive and the confirmatory test is negative (discrepant results) both the rapid HIV test and the confirmatory test should be repeated. A consultation with an infectious disease specialist is recommended. If the rapid HIV test does not provide a valid test result, most likely the test kit did not work properly and the rapid HIV test should be repeated.[12]

Counseling Patients with a Negative HIV Rapid Test

Patients whose rapid HIV test result is negative can be told that they are not infected, unless they have had a recent (within 3 months) known or possible ex-

posure to HIV. Retesting should be recommended for these clients because sufficient time needs to elapse in order before development of the antibodies that are detected by the test.[14]

Counseling Patients with a Preliminary Positive HIV Rapid Test

Confirmatory testing is always required to confirm a reactive rapid HIV test result. The challenge is providing reactive (preliminary positive) results to patients without the benefit of a same-day confirmatory test. For all patients with a reactive rapid HIV test result, however, it is essential to:

- Explain that this is a preliminary test result that needs to be confirmed.
- Emphasize the importance of confirmatory testing and schedule a return visit for the confirmatory test results.
- Underscore the importance of taking precautions to avoid the possibility of transmitting infection to others while awaiting results of confirmatory testing.[14]

New Jersey and Federal Licensure Requirements for Rapid HIV Testing

Federal Requirements

The Centers for Medicare and Medicaid Services (CMS) regulates clinical laboratory testing under the auspices of the Clinical Laboratory Improvement Act (CLIA). CLIA defines a laboratory as "any facility which performs laboratory testing on specimens derived from humans for the purpose of providing information for the diagnosis, prevention, treatment of disease or impairment of, or assessment of health." In 1992, CLIA implemented regulations based upon the complexity of lab methodology and divided laboratory testing into groups that are either waived, moderate in complexity, or of high complexity. Federal regulations require that a waived laboratory must simply complete an application, enroll in CLIA, pay a fee, become certified and perform testing in accordance with the manufacturer's product insert. Requirements in New Jersey are more complicated because of state regulations which are more restrictive.

New diagnostic tests are reviewed on at least two levels. The FDA reviews a proposed test for marketing and if appropriate, performs a second, separate review to determine whether a test qualifies for CLIA waiver status. The complexity designation determines the stringency of CLIA requirements that a testing site must meet in order to perform testing and assure quality.

As part of the CLIA review process, manufacturers that want a test waived submit a waiver application to the FDA accompanied by supporting data. If the FDA finds that data provided to them by the manufacturer establishes simplicity and safety in use by individuals of limited technical experience, they may grant a waiver that permits them to be performed in a variety of health care settings by personnel meeting requirements defined in the package insert.

In reviewing the OraQuick rapid HIV test for CLIA waiver, the FDA determined that:

1. The sale of OraQuick rapid HIV tests would be restricted to clinical laboratories
   - That have an "adequate quality assurance program including systematic activities to provide adequate confidence that requirements of quality would be met."
   - Where there is " assurance that operators will receive and use instructional materials."
2. The test was approved for use ONLY by agents of the clinical laboratory.

New Jersey State Requirements

Currently, with the exception of small group practices (fewer than four physicians), clinical group practices and other organizations performing clinical laboratory testing in New Jersey are required to have a New Jersey Clinical Laboratory License. New Jersey regulations are more restrictive than the federal regulations and provide and recognize only a subset of the original CLIA list of waived tests. Rapid HIV testing, which is waived nationally, is not recognized as a 'waived' test within New Jersey.

New Jersey regulations require that interested parties complete an application specifying the procedures to be performed, the personnel performing the procedures, the Bioanalytical Laboratory Director, and also require laboratories to participate in proficiency testing for each of the tests that they perform.

Under a special 'Limited Purpose Laboratory' provision, public health laboratories funded by the Division of HIV/AIDS Services, are licensed to provide rapid HIV testing. This provision allows multiple facilities employing the same quality assurance program to operate under a single Bioanalytical Laboratory Director, a significant advantage, because New Jersey law currently limits directors to a maximum of 3 facilities within the state.

Conclusion

Rapid diagnostic HIV testing can be integrated into daily practice. Persons found to be infected with HIV should be referred for medical care by a provider with experience and expertise treating HIV disease, be referred for prevention services, and be referred for social services. In addition, New Jersey regulations (New Jersey Administrative Code 8:57-2.2) require that persons infected with HIV be reported to the NJDHSS, DHAS Surveillance Program.

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IT Committee of HFMA New Jersey

Diane Tobin, Chair
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The Importance of Passwords

Submitted by: Jack Tenerelli, CNE, MCP, Network+ *

Password Facts:

- A six character password using all upper-case letters or lower-case letters has 308 million possible letter combinations. It can be guessed within minutes!
- A six character password using a combination of upper and lower-case letters results in 19 billion combinations.
- An eight character password using upper and lower case letters, has 53 trillion combinations.
- An eight character password, using upper and lower case letters, while also substituting a letter for a number, gives you 218 trillion possible combinations.
- Most common passwords: password, pet's name.

Not another password to remember! How many times have you said that over the past few years. If you are like most of us, too many. These days there is a password for everything, your home computer, your work computer, network, cell phone, work phone, internet email, in-house applications and so on. How many passwords is someone expected to come up with, you ask. You only have so many spouses, kids, and pets.

Some commonly used passwords:

- Name of spouse
- Name of children
- Name of pet
- Favorite sport
- Favorite sports team
- Hobbies

Take this list of most commonly used passwords. Do you see one or more of your passwords in the list? Guilty as charged! Either people do not take password creation very seriously, or treat it as a nuisance. In many cases this is simply a matter of lack of training. People need to be aware of how important the information that they are protecting is. They need to understand why their passwords are so important, and the different types of attacks that are being used to guess their passwords on a daily basis.

Look at the password facts. At first glance, someone may think "308 million possible combinations, I'm safe". But, when they read on and see that a password cracking program can guess it within a few minutes, they might think again. This is why they need to know how to create strong passwords.

Why are passwords important?

Passwords are considered the weakest link in any security policy. Why? Because people choose passwords that are easy to remember. Unfortunately, passwords that are easy to remember are also easy to guess. Hackers use tools that take advantage of your behavior. Take the list of commonly used passwords. If someone can get your name and find out some information about you, chances are good that they can guess your password. They now have a foothold in your network. They can use your information to get into your network and go on from there. People feel secure in the knowledge that there is a good perimeter defense around them. Unfortunately, this is a false sense of security.

Users also need to understand the repercussions that their organizations can face in the aftermath of a security breach. They can be sued. There can be fines levied against them, and loss of reputation or even criminal penalties. All of which can affect your job.

To make it more personal, consider this; a password tells the system that you are who you say you are. If someone logs in as you, there is the possibility of the perpetrator causing a lot of mischief and grief for you. They can send out emails as you, and they can delete information leaving an audit trail pointing directly to you. They can steal your identity. Think of the hassle of trying to explain and make right all of the damage. Then think of how much easier it would be if you just used a better password.

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Attacks against passwords

Dictionary attack - The attacker systematically tests words which would most likely be used as a password beginning with words that have a higher probability of being used; such as names and places. Remember we spoke about some common passwords. This attack is successful because people have a tendency to choose passwords that are easy to remember. This also includes foreign words.

Brute Force Attack - this attack is similar to the dictionary attack, the difference is that it uses every possible combination of characters starting with A, AA, AB, etc... Using this method, the attacker is guaranteed to eventually guess your password.

The way to beat this attack is to create a password that will take too long to guess, a strong password. The size and complexity of your password will help to dictate how long it will take to guess it. It can range from a few hours to a hundred years. Look at the table below to see the difference a few characters can make in the amount of time it takes to guess a password.

Password lengths – 4, 6, 8, 10
Available # of characters in each set:
26 - # of lower case characters
36 - # of letters and digits (0 – 9)
52 - # of mixed case letters
68 - # of single case letters with digits, symbols and punctuations

These numbers were added to illustrate how much more difficult you can make it for someone to guess your password just by adding a few characters. They will differ based on different factors including computing power. Considering that as computers become more powerful in the future, the time it takes to guess a password decreases. Also, don't just use complexity as a guide for creating passwords. Consider randomness as an extremely important factor.

Take passwords seriously.
It is the
simplest way
to protect
your information.
The difference between
a few characters
can be all it takes
to keep attackers out.

For example, if you use an eight character password 1111AAAA, it can be guessed easily.

Over the shoulder attack (Shoulder Surfing) - This is when someone observes you entering in your password.

Length of password	26 character set	36 character set	52 character set	68 character set
4	5 seconds	16 seconds	2 minutes	4 minutes
6	1 minute	6 hours	13 days	3 months
8	24 days	11 months	17 years	1.45 centuries
10	44 years	1 millennia	45 millennia	Forget about it!

Password guessing – Attacker attempts to logon using the user's account by repeatedly guessing likely words or phrases, (i.e. children's names, city of birth, or local sports team).

Other related attacks

Social Engineering - The classic social engineering attack is carried out over the telephone (email is now also being used). Someone can pose as a computer technician from the helpdesk or an associate of a senior manager and talk someone into innocently revealing passwords or other information.

Believe it or not, this tactic is still used because of its effectiveness. Social Engineering takes advantage of the fact that people are easily lulled into a false sense of security to give away information like: Passwords, usernames, or other facts about users or themselves that can be used during a later attack.

No matter how good your security is, this attack can break it. The way to thwart this attack is to educate users. Let them know that they should never reveal theirs or anyone else's password. They should also verify the identity of anyone wishing to get such information.

Dumpster Diving – Is an old but very successful method. This attack involves going through a company's trash looking for documents that include important network, corporate or user information (even a roster of employee names). What can someone do with a list of employee names? If someone knows a user's name they can then figure out the login name (most companies use the first initial and last name). They can now use that information along with any other information they've gathered to gain access to the corporate network.

Phishing – Is an attack in which an email is sent claiming to be from a legitimate enterprise in an attempt to scam

the user into surrendering private information. The email diverts the user to visit a website where they are asked to update personal information. The website mimics the original company's website. If you are suspicious, a good way to spot these is to move your mouse pointer over the links in the email to see what the real URL is.

The term "phishing" arises from using sophisticated lures to "fish" for user's financial information and passwords. Look for spelling mistakes in the subject or body of the email. This is a sign of phishing.

Now that we know about some of the attacks used to guess passwords, let's take a look at some weak passwords, and then go over the rules for creating strong passwords to prevent such attacks.

Characteristics of weak passwords:

- Less than 8 characters
- Your user name
- Addresses and places
- Words found in a dictionary (English or foreign)
- Common usage words or something about you such as:
  - Names of family members or pets, fantasy characters, computer terms, birthdays, other important dates, addresses, phone numbers or other personal information
- Word or number patterns (aaabbb, qwerty, zyxwvuts, 123321)
- Any of the above spelled backwards
- Any of the above preceded by or followed by a digit (i.e. secret1)

Sound Familiar!

Let's look at some of the characteristics of a strong password:

- At least 8 alphanumeric characters long
- Contain both upper and lower case characters, digits and punctuation characters i.e. ImaGr8skAtr! (don't use this one, it's a popular example)
- Not a word in any language, slang, dialect, or jargon
- Not based on any personal information
- Should not be written down or stored online
- Can be typed quickly, thus making it harder to steal

Network and computer administrators can enforce some of these rules by creating policies which will require users to change passwords every x number of days, or by having the system remember previously used passwords and forcing the user to create a new password.

Take passwords seriously. It is the simplest way to protect your information. The difference between a few characters can be all it takes to keep attackers out. Remember password creation is a balance between security and usability. Don't create passwords that you can't remember and have to write down on a sticky pad that you will place on your monitor. By doing so, you have defeated the purpose of having a strong password.

Don't leave security up to someone else. Everyone has to do their part and computer usage in a secure environment will become a universal reality for all of us.

About the Author

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NOTICE

Please be advised that the 2006-2007
NJ HFMA Strategic Plan
is now available to
all New Jersey Chapter members.

Please visit the link below to our
website to view this document.

http://www.hfmanj.org/site/files/427/
13753/145343/202983/HFMA
StrategicPlan20062007.doc

CFO Spotlight: Dave Rikkola, Newton Memorial Hospital

Dave Rikkola

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

DAVE: My career in healthcare started a long time ago at Atlantic City Medical Center as a grant analyst. I moved into the reimbursement arena at ACMC as they became one of the guinea pigs for the DRG system. From there, I moved to a start-up consulting firm called Kaden and Arnone Associates – I was their first employee. It is amazing to me that so many of my colleagues at the time, Rich Miller, Sam Donio, Joanne Vaul, Fred Stodolak, Cheryl Cohen and Bob Nyman, just to name a few, are still active in healthcare and HFMA. I spent a number of years at KA and ultimately became President of the firm. During my years there, I was intimately involved with a wide range of projects that focused on reimbursement, revenue cycle and strategic growth. I spent several years at Somerset Medical Center as VP of Strategic Development before coming to Newton Memorial Hospital as CFO over a year ago.

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

DAVE: In some ways it seems like a natural evolution. I have spent virtually my entire professional career in the healthcare field focusing on revenue enhancement and strategy implementation. I feel that my diverse background has prepared me well for my position in financial leadership. I will admit, however, that it is a far different thing to present a consulting report than to implement the report's recommendations.

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

DAVE: Technical financial skills and knowledge are of course essentials for CFOs within any industry. The non-profit healthcare industry demands extra skills. One of the most important skills necessary to be a successful hospital CFO is the ability to balance mission and margin. The reality is that there are never enough resources to do everything. True financial leadership involves optimizing reimbursement and cash while controlling expenditures in a manner to best meet the mission of the institution. I think that another important skill for a hospital CFO to have is that of expert communicator. It is not enough to understand the financial issues faced by hospitals, rather, it is critical to communicate these issues to all of the hospital's constituencies – the community, medical staff, payer community, board of directors, employees, politicians and bond holders.

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

DAVE: I must say that in all my years in healthcare, Newton Memorial Hospital is one of the friendliest hospitals I have ever been in. Newton is an independent community hospital located in Sussex County. We are the leading institutional provider of healthcare in the county and provide a full range of non-tertiary services.

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

DAVE: Newton Hospital, like many New Jersey hospitals, is facing some facility issues. We are currently evaluating a building program to expand/modernize our facility to provide 100% single bed-

ded rooms. We have recently built a new emergency department and are currently building a Cath Lab. We are also in the process of implementing Cerner as our hospital-wide IT solution.

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

DAVE: We have two outstanding Bond issues through the NJHCFFA – one from 1997 and one from 2001. We are in the early stages of evaluating future capital needs relative to the expansion / renovation plans currently under consideration.

FOCUS: What are your spare time activities?

DAVE: As a father of five, much of my spare time is devoted to family activities mostly involving sports and school. I am pleased to say that everyone in the family has fallen in love with golf – the seven of us hit a lot of golf balls!! Beyond golf, my personal interests include skiing, reading and numismatics.

FOCUS: What are your professional memberships?

DAVE: I am a member of the HFMA and a Board Member of the Foundation for Sussex County Community College

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

DAVE: My wife Christine, my family and the essentials – golf clubs, books, dominos, wine and my jukebox.

Member Spotlight: Lisa R. Hartman

by James Yarsinky, CPAM

Lisa R. Hartman

Jim, my career has come full circle with a B.A. in biology and a Masters degree in Public Health (M.P.H). In the early part of my career I was especially interested in health policy and health regulations. My first job was a research position with the New York State Department of Health that was conducting data analysis to support the development of the Medicare Prospective Payment System (PPS). I was then given the opportunity to help a major specialty hospital in NYC determine if it should stay on cost based reimbursement or move to PPS. This launched my career in health finance, which I have always found to be fascinating, especially never having taken a business class or an accounting class! My next involvement was program planning, cost accounting, and revenue budgeting for a large academic medical center in NYC. When ready to start a family, I moved to New Jersey and started working at a community hospital as a Director of Reimbursement. As New Jersey moved towards deregulation, I began managed care contracting, first on the provider side and then the payer side. This led me to an opportunity at the Princeton HealthCare System (formerly The Medical Center at Princeton) in 2000. My first position was as the Director of Contracting, but I was often asked to take on "little" side projects because of my finance background. When asked to lead an initiative to update the health system's charge master, it demonstrated I could lead a large scale project on time and within budget. Later on I was asked to take on responsibility for Corporate Compliance and HIPAA privacy. I gave up my role in managed care to devote my resources to Corporate Compliance and HIPAA activities.

FOCUS: Lisa, please talk about your duties at Princeton Healthcare System.

LISA: At Princeton HealthCare System I am the Director of Compliance and Audit and serve as the organization's Compliance and Privacy Officer. In this capacity, I am responsible for Corporate Compliance, HIPAA Privacy and Security, Internal Audit, and Ethics Management (I launched the internal audit and ethics program at Princeton Healthcare System). More recently, my responsibilities include JCAHO activities. I am the administrative liaison for two committees of the Board of Trustees, Internal Audit

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and the Ethics Committee. All in all, I feel like I am finally using the skill sets I originally envisioned for my career when I received my M.P.H.

FOCUS: Name a few challenges that compliance officers face in organizing an effective compliance program.

LISA: Jim, there are many challenges facing a compliance officer today. To name a few, I would include staying on top of regulations that are continually evolving, education of the workforce to understand their roles and responsibilities in contributing to an effective compliance program, being able to respond on a timely basis to issues as they develop, and in some cases developing an appropriate corrective action plan, reliable monitoring and auditing practices and risk assessment as well as having effective communication with all levels of the organization including board members, management, physicians and staff. Also, doing all of the above with limited resources to support the process.

FOCUS: What does it take to be an effective director of compliance and audit?

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LISA: To be an effective Director of Compliance and Audit, one has to be able to juggle many things simultaneously, keep abreast of all the changes in the industry and absorb a great deal of information, be prepared for the unexpected, respond to issues in a calm rational way and provide leadership in complex situations. I also think you need to have a vision for yourself and your organization and to continually set the bar higher to achieve more. Compliance and audit is a process of continuous improvement.

FOCUS: What greatest changes have you witnessed in your position over the years?

LISA: Having only been in the role of Compliance Officer for about three years everything I do, (compliance, HIPAA, internal audit, ethics management, JCAHO) is all relatively new to me. I am always learning! I feel privileged and blessed to have had the opportunity to get involved the NJHFMA compliance and ethics committee, first as a member, then as a co-chair, then as chairperson and now as their Board liaison having been inducted as a Director on June 13, 2006. I am inspired by the knowledge and support of the committee members.

FOCUS: What advice can you give others that are interested in compliance and auditing?

LISA: Never be afraid to ask questions, read as much as you can, participate in seminars and conferences to stay current in your field, and be willing to learn as you go. Of course, I would recommend that they join the NJHFMA Compliance and Ethics committee!

FOCUS: What are your hobbies and outside interests?

LISA: This question truly made me laugh! I am a single mom of 3 boys ages 16, 11 and 8 so I guess my hobbies and interests these days include helping with homework, chauffeuring to activities, and raising them into responsible men. In my "free" time, I enjoy daily fitness walking, reading the NY Times and romantic murder mysteries.

FOCUS: Thank you Lisa for taking time out of your hectic schedule to be interviewed for this edition of FOCUS.

LISA: My pleasure!

About the Author

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The 2006 NJ HFMA Scholarship Recipients

by Laura A. Hess, FHFMA

The New Jersey Chapter of the Healthcare Financial Management Association awards at least one scholarship each May. Eligibility for the scholarship is based on the following criteria:

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

Preference is given to applicants pursuing degrees in finance, accounting, healthcare administration or a healthcare related filed of study. Tuition not paid by an employee or other scholarship qualifies for the HFMA scholarship.

Our selection is based on merit, academic achievement, civic and professional activities, course of study and content of the application and essay.

This year, our chapter received 16 scholarship applications! At our June 13, 2006 Quarterly meeting, Stella Visaggio, on behalf of Rick Parker, was happy to announce that our chapter would be awarding four $3,000 scholarships this year. The 2006 recipients are: Julie Andreola, Stacey Duchak, Kimberly Jones, and Laura Mann.

Julie Andreola is the daughter of members Kathy & Frank Andreola. Frank Andreola is Finance Director at Aptium Oncology at Trinitas Hospital, while Kathy is a Patient Accounts Manager at Meridian Health. Julie has just completed her freshman year at Monmouth University, where she is pursuing a degree in Business Administration/ Marketing. At the time of application, Julie achieved a GPA of 3.74, meeting the requirements for Dean's list. In addition to her academic achievements, Julie has maintained a part-time position at Jersey Shore University Medical Center since 2003.

Stacey Duchak is the daughter of member Doug Duchak, President & CEO of Englewood Hospital. Stacey will be pursuing a degree in speech pathology at Boston College. She completed her high school career with a GPA of 4.0! In addition, Stacey has also maintained part-time positions and community activities, including working with handicapped children in various capacities.

Kimberly Jones is the daughter of Dennis Jones, Director of Account Management at Executive Health Resources. She has just graduated her high school's gifted and talented program with a GPA of 3.7, and will be pursuing the degree of Doctor of Physical Therapy.

Our final recipient for 2006 is Laura Mann. Laura is the daughter of Gary and Kathy Mann, who have both been active members of the NJ HFMA Chapter. Gary is curently the managing partner of KGKL Enterprises. Laura has just graduated the Mount Saint Mary Academy with a G.P.A. of 3.96. In addition to being a top student, Laura also has many accomplishments in athletics and community service. She has also maintained various part-time positions. Laura will be attending Loyola College in the fall, where she plans to pursue a Business degree, focusing on accounting and finance.

Congratulations and good luck to Julie, Stacey, Kimberly and Laura, as well as our additional twelve 2006 applicants, as they continue their education and pursuit of their goals.

Frank Andreola, Julie Andreola, Kathy Andreola, and Stella Visaggio

The June Quarterly Meeting Healthcare Environment Update –"Just the F.A.C.T.S." June 13th, 2006

by Anthony J. Panico & Scott J. Mariani

Introduction/Officers/Scholarships

John Manzi, President for the NJ Chapter of the HFMA, welcomed members to the HFMA FACT Committee Quarterly Meeting. He proceeded to recognize four committees for achieving the highest award by HFMA; The Yerger Award. This year's recipients of The Yerger Award were (1) Governance Compliance, (2) NJHFMA 2005 Annual Institute, (3) the Social Committee and (4) CFO spotlight. This was the first time that the Social Committee has been recognized with this award.

Stella Visaggio, Past President of the NJ Chapter of the HFMA, then recognized the four scholarship winners.

Following the recognition of the scholarship winners all current Board members were recognized for their contributions for their efforts during the past year. The introduction of the new Board members for the upcoming year ensued and included Dotti Lindstrom as the new President and Cheryl Cohen as President Elect of the NJ Chapter of the HFMA. Laura Hess was thanked for her contributions during the past year as well. Following the presentation of the new Board members, Dottie Lindstrom presented John Manzi, outgoing President, with the President's plaque.

Morning Session

NJHA Update

Roger Sarao of the New Jersey Hospital Association (NJHA) began the morning session with a general update on various State of New Jersey healthcare issues. He announced the government budget proposal of $30.9B; an increase of $3.5B from the prior year (includes a $4.5B deficit). The current budget proposal includes an increase in the state sales tax rate to 7%, increases in the cigarette, alcohol and water utility taxes, increased registration fees for luxury automobiles, the elimination of approximately 1,000 state jobs, restoration of $50M to the unemployment pension fund, the elimination of hospital assistance grants totaling $62.4M, a reduction in partial hospitalizations totaling approximately $20M (includes federal match of $10M), additional state revenues resulting from the collection of copays on Medicaid prescription drugs ($13M) and bad use of emergency rooms ($1.1M), a $24M reduction through the elimination of the cost increase to Medicaid nursing home rates (this would forgo the federal match as well) and, most significant, the imposition of a "bed tax" on New Jersey hospitals.

The State of New Jersey is attempting to implement a bed tax that will be levied on the number of licensed beds in a hospital. The bed count per hospital will be obtained from the hospital licensure with the state which is acute care beds less bassinets. The proposed amount of the tax is $1,424 per bed per month. As it stands now this would generate $430M in revenue for the state. Of this amount $215M (one half) would go to the general revenue of the state. The other half would go back to the hospitals depending on Medicaid utilization; an amount that would be matched federally. The $430M to go back to the hospitals would be in the form of direct DRG payments and fee for service. The state currently projects that 49 hospitals would have a net increase in payments while 25 hospitals would have a net decrease. The NJHA is currently working against the bed tax. Overall the bed tax will hurt hospitals with low Medicaid usage and unfairly benefit small hospitals with large Medicaid numbers. Ultimately the bed tax could force hospital closures and will actually cost patients more as the hospitals pass on the cost to the patient. Visit their website at www.njadvocacy.com to generate an automatic letter to local legislators opposing the bed tax. To date more than 8,000 letters opposing the bed tax have been received.

With respect to the reduction in partial hospitalizations the state is looking to achieve savings through the implementation of standards and prior authorizations to qualify for hospitalization (children's services are excluded).

Scrutiny of Tax-Exempt Organizations

Julius C. Green, J.D., CPA, a Principal with Parente Randolph, provided an update on increased government scrutiny of tax-exempt hospitals. Mr. Green began his presentation with a discussion on provisions of the Senate Bill – Tax Relief Act of 2005 and examples of congressional and independent sector proposed reforms. Highlights of the congressional and independent sector efforts include broad and sweeping reforms directed at charitable organizations, a continuing active Senate Finance Committee, charity care continuing to be a major focus, implementation of IRS guidelines and a continued focus on executive compensation and benefit issues.

The Tax Relief Act of 2005 provides for concern over misuse of IRC Section 509(a)(3) supporting organizations, a common classification for health system parents and foundations. Limitations on these organizations could preclude exemption by health system parents and/or foundations. Other highlights of the Act include new rules for donor advised funds and making Form 990-T open to public inspection.

Mr. Green went on to discuss significant examples of proposed reforms. In addition to considering the abolishment of and/or significant restrictions placed on IRC Section 509(a)(3) supporting organizations Congress would require a reapplication for tax-exemption every five years and a requirement for conflict of interest policies to be adopted and enforced. The reforms would require a certification by the organization CEO and CFO that the Form 990 is filed in compliance with federal tax laws and a suspension in charitable status for failure to comply with Form 990 filing requirements for two consecutive years.

Mr. Green provided a review of the IRS 2006 work plan. The IRS published its 2006 Implementing Guidelines in October of 2005 and it includes initiatives such as (1) executive compensation, (2) hospitals (executive compensation and charity care), (3) 509(a)(3) supporting organizations, (4) tax-exempt bonds; private use, (5) comprehensive overhaul of Form 990 and (6) education and training.

A review of the IRS 2005 executive compensation enforcement initiative in which compliance letters were sent to approximately 1,800 organizations results followed. The preliminary results (final results and findings will be issued in Fall of 2006) were that charities are attempting to hide compensation, not properly disclosing loans to key employees and not properly reporting miscellaneous items of compensation and benefits.

Mr. Green concluded his presentation with a discussion on the current IRS initiative taking place in the form of an IRS Questionnaire (Compliance Check Questionnaire Tax-Exempt Hospitals) which has been issued to approximately 600 hospitals across the country. The Questionnaire is largely focused on community benefit. He touched on Sarbanes-Oxley and how it relates to tax-exempt organizations, intermediate sanctions with a focus on the definition of intermediate sanctions and who disqualified persons are, the rebuttable presumption of reasonableness and unrelated business income issues.

Creative Financing Solutions with Derivative Instruments

The morning session also included a panel discussion relative to current financing alternatives utilizing instruments such as derivatives. The panel consisted of Jan S. Blazewski, Senior Vice President Cain Brothers & Co.; Bart A. Plank, Senior Vice President Cain Brothers & Co.; Joseph R. Marion, managing Director, Health Care and Higher Education Group, Merrill Lynch; and Damon E. Lee, Vice President, Municipal Derivatives group, Merrill Lynch.

The discussion began with a current market overview indicating that organizations can segregate risks based on how comfortable it is with risk. Transactions can be tailored to meet the level of risk desired. Over the past five years derivative instruments have become an increasingly prevalent element of efficient tax-exempt borrowing strategies, particularly in the healthcare arena because of their ease of implementation, more sophisticated balance sheet management strategies, assistance in the improvement of cash flow in the healthcare operating environment, flexibility and outcomes. Standard & Poors estimated that over 50% of its rated healthcare credits have entered into at least one interest rate swap contract. The size of the tax-exempt swap market is estimated to be over $1 trillion, a small fraction of the total interest rate swap market estimated at approximately $215 trillion. Overall, interest rates drive what particular strategy works at a specific point in time.

The discussion ensued with an overview of Comprehensive Asset Liability Management (CALM). Through the CALM process, hospitals adopt a risk based approach to raising and investing capital.

With the fixed rate strategy borrowers can lock in fixed rates applicable to future debt issuance based on today's favorable long-term interest rates by entering into Forward Starting Fixed Pay Swaps.

The discussion then reviewed synthetic variable rate market opportunities. The panel speakers stated that variable rate debt has historically yielded a lower cost of funds than the fixed rate and that low interest rates for long-term fixed rate bonds and narrow spreads create an opportunity to achieve synthetic variable rate funding below that of the cash market.

The panel informed attendees that

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fixed spread basis swaps can help the healthcare borrower by reducing the interest expense on fixed rate bonds. The fixed spread benefit is 43 basis points of annual cash flow, assuming a BMA (floating rate cost of seven day weekly reset demand bond in the marketplace) average of 67% 1-month LIBOR.

In summary, the panel stressed that capital structure decisions should be made in the context of the entire balance sheet and asset/liability management, locking in fixed rates on a forward basis is attractive from a historical perspective, synthetic variable rate debt offers a cost effective method of achieving variable rate exposure while avoiding remarketing and re-pricing risks and basis swaps provide an annual cash flow benefit and can be used to reduce debt service. How an organization implements derivatives depends on the current market environment. Swaps are not like bonds; they are very flexible and you are not locked in.

GAAP Update

The morning session concluded with a GAAP update, recent developments and issues in healthcare accounting, presented by William I. Stulginsky, Partner with PricewaterhouseCoopers. Mr. Stulginsky reported on recent healthcare hot topics including accounting for alternative investments, other than temporary impairment and securities lending. Following his discussion on accounting for alternative investments he provided an overview of general FASB developments including effective dates of selected FASB standards, new FASB standards, exposure drafts and other FASB projects. Mr. Stulginsky concluded his presentation with a discussion on AICPA developments including proposed revisions to the Health care Audit Guide. These proposed revisions would affect the basic financial statements, cash/investments, derivatives, PP&E and other assets, tax-exempt debt, contributions, charity care, revenue recognition self-pay and third party settlements.

Afternoon Session

Decision Support and Benchmarking Alternatives

The afternoon session began with a panel discussion relative to decision support and benchmarking activities. Ylone S. Xavier, Vice President for Decision Support, Saint Barnabas Health Care System (SBHCS), began the discussion with an overview of the functions that are centralized under SBHCS corporate and the various modules that SBHCS utilizes. She stressed that in order to fully utilize the benefits of the activities her department established credibility in the basics of the information provided, introduced expected payments using reimbursement modeling (compared to actual payments), introduced the importance of costing (developed RVU based costing), introduced the concept of profitability using expected payments and costs, examining profitability, building trust in the numbers and thinking out of the box! Ms. Xavier stated that the clinical side of the information allows your mind to take off and that it remains a challenge to get the staff to use the information as it is presented. She concluded by advising decision support departments to sell the department, product and people, align with champions, act as if you are running a consulting practice and you need to produce information that your staff wants to buy and to always try to be ahead of the curve.

Sam Donio, President of CBIZ KA Consulting, continued the panel discussion with an overview of the three types of costing that are predominantly used in the decision support system including Activity Based Costing (ABC), Relative Value Unit Based Costing (RVU) and Ratio of Cost to Charge Costing (RCC). He went through the pros and cons of each type of costing stressing that a combination of ABC and RCC is the way to get the best of both worlds and get the true answer.

Jim Morrisy, President/CEO of Healthware Concepts concluded the panel discussion by presenting the advantages of using an Application Service Provider (ASP) for decision support, decision support pitfalls and opportunities and new reporting techniques for improved business intelligence. ASP models do not require a large capital investment, can be implemented quickly, require no start up costs with monthly subscription based fee structure, have no down time when upgrading and are secure and mobile. Decision support is external from a hospital's other applications such as billing and patient accounting and focuses on revenue valuation. New reporting techniques utilize row and column reports (e.g. Excel), charts, graphs and maps. The user should be able to run their own reports and the report writer should allow for flexible filtering as well as drill downs. Mr. Morrisy concluded the discussion by reviewing snapshots of new reporting techniques that included the utilization of data warehousing, rows and columns, charts and maps or any combination thereof.

Anatomy of the Bond Financing Process

The afternoon session continued with a presentation by Chuck Toto, partner with Hawkins, Delafield & Wood, L.L.P. on the anatomy of the bond financing process. He began his discussion with an overview of the parties involved in the process or the bond financing team. Due diligence is performed by bond counsel and underwriting counsel by identifying support for the legal opinion, support for the official statement and an analysis of bond proceeds relative to private use issues. Mr. Toto continued with a summary of disclosure items in the primary and secondary markets and

documentation required including loan agreement, master indenture, bond indenture, bond purchase agreement and accountant's letters. Mr. Toto concluded his discussion with a review of current issues in the tax-exempt bond financing market including the current IRS initiative relative to audits of tax-exempt bonds focusing on healthcare organizations wherein he stressed the importance of the 95/5 rule of tax-exempt bond proceeds and recordkeeping.

Current Tax Issues Update

The afternoon session concluded with a presentation by Felicia Tucker, Manager with Ernst & Young, L.L.P. and Chris Boggs, Manager with Ernst & Young, L.L.P. Ms. Tucker discussed the revisions to the 2005 Form 990 and the substantial revisions expected on the 2006 Form 990. Chris Boggs concluded the presentation with a discussion relative to the e-filing requirements for the 2005 Form 990. He stressed the importance of beginning the process sooner rather than later due to the fact that this is the first time Form 990 has been required to be electronically filed with the IRS. He explained instances wherein he experienced major difficulties and diagnostic problems in e-filing a 2005 Form 990 whether it be software or the IRS issues.

The day concluded with FACT Committee Chair Dave Wiessel and Vice Chair Heather Weber thanking all participants and presenters for a very informative day.

About the Authors

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•Focus on Member News•

EDISON - Amper, Politziner & Mattia, Certified Public Accountants and Consultants, is pleased to announce that Michael McLafferty has been promoted to Officer of the firm's Healthcare Services Group.

Michael McLafferty CPA, MBA, CHFP, FACMPE serves as a business advisor to hospitals, physician groups and ambulatory surgery centers in the areas of practice management, managed care contract negotiations, regulatory compliance and strategic planning. McLafferty received a Master of Business Administration from Rutgers University and a Bachelor of Science Degree from Brooklyn College and has more than 20 years of healthcare business advisory experience.

Mr. McLafferty is active in numerous associations, including the American College of Healthcare Executives, the Healthcare Financial Management Association, the Medical Group Management Association, and the New Jersey Society of Certified Public Accountants.

Amper, Politziner & Mattia, a member of the AICPA's Major Firms Group, is a regional Certified Public Accounting and Consulting firm serving the greater New Jersey/New York business community for 40 years.

FOR FURTHER INFORMATION, PLEASE CONTACT
Karen Tortoriello - (732) 287-1000 - tortoriello@amper.com

PATERSON--July 10, 2006—Joseph Germinario, President of Allstate Information Management, has appointed Thomas Garlick as Allstate's newest Account Executive.

In making the announcement Mr. Germinario said, "Thomas will assume responsibility for enriching our client relationships." Allstate Information Management, which provides records and data management services, will use Garlick's background in sales to introduce clients to the myriad of value-added services available to them.

Mr. Garlick comes to Allstate with 25 years of sales experience with AT&T and BMW. In 1999 he received the National Corporate Care Recognition Award for his consultative care and customer retention programs.

•Focus on New Jersey Chapter News•

NJ Chapter Earns Four Yerger Awards at ANI!

RC Photographic Productions

Cheryl Cohen, 2005-2006 NJ Chapter Vice President, accepts the Chapters four Yerger Awards at the Annual National Institute.

On June 19, 2006, at a celebration following the Chapter Presidents Meeting and Dinner during the Annual National Institute in Orlando, Florida, Cheryl Cohen had the priviledge of accepting four Helen M. Yerger Awards on behalf of outgoing NJ Chapter President, John Manzi, and the NJ Chapter.

The Helen M. Yerger Award recognizes outstanding chapter performance in the categories of Collaboration, Education, Improvement, Innovation, Member Communications, Member Service, and Membership Recruitment and Retention.

Each year, chapters may submit a total of four single-chapter entries and there is no limit for multi-chapter submissions. Award submissions will be judged by the following criteria: needs identification, 20 points; goals and objectives, 20 points; methodology, 15 points; evaluation, 15 points; and results, 30 points. Chapters that receive at least 75 points earn Helen M. Yerger Special Recognition Awards.

Our chapter received awards for the following entries:

Education Award:
Goverance Survey on Compliance, submitted by John Reiss for the Compliance Committee

Improvement Awards:
NJHFMA 2005 Annual Institute, submitted by Caitlin Zulla for the Institute Committee

Institute Networking Function, submitted by Karen Johnson for the Social Committee

Member Communications Award:
CFO Spotlight Feature in the FOCUS magazine, submitted by Joan Hendler for the Publications Committee

Congratulations to all!

NJ HFMA Chapter Inducts 2006-2007 Board and Officers

At the NJ HFMA June Quarterly Meeting on June 13, 2006, outgoing President John Manzi recognized and thanked the outgoing NJ HFMA Board of Directors and Officers for a very successful year. He also inducted the chapter's incoming Officers and Board of Directors.

The new Board of Directors is as follows:

Dorothy Lindstrom – *President*
Cheryl H. Cohen, FHFMA – *President Elect*
Joseph J. Dobosh , Jr.– *Vice President*
Brian P. Sherin, FHFMA – *Secretary*
Robert C. Peterson, CPA – *Treasurer*

Board of Directors:

Susan D. Bonfield	Lindsey A. Colombo, CHFP
Lisa R. Hartman	Marilyn A. Koczan, FHFMA
Anthony T. Orlando	Jim Pender
John B. Reiss, PhD, JD	Mary T. Taylor, FHFMA
David J. Wiessel	

Advisory Council:

John Manzi	Richard C. Parker
Stella M. Visaggio, CPA	John Calandriello, FHFMA, CPA
Michael J. Monahan, FHFMA	

Thanks to all for volunteering their time to our chapter. We wish you all a successful year!

2006 President's Award

Caitlin Zulla, CHFP, and Olga Barone-Allen, co-chairs of the 2005 Institute Committee, were recently awarded the 2006 President's Award by outgoing President, John Manzi.

At the Chapter's June 13th quarterly meeting, Olga accepted crystal awards for both ladies, as lucky Caitlin was busy taking a well-earned vacation in Greece!

In addition to the crystal statues, recipients of the President's Award attend the Chapter's Annual Institute, including registration and hotel rooms, as guests of the NJ Chapter. Congratulations to both Caitlin and Olga on a job well done!

Patient Assistance Programs & Medicare Part D

Patricia Barron

by Patricia Barron, Esq.

As you all likely know by now, effective January 1, 2006, any individual who is entitled to coverage under Medicare Part A or enrolled in Medicare Part B is also eligible to purchase coverage for outpatient prescription drug coverage under Medicare Part D. What you may not know, however, is how Medicare Part D will affect various prescription drug subsidy programs, including Patient Assistance Programs ("PAPs") sponsored by pharmaceutical manufacturers.

Historically, PAPs have provided cash subsidies and/or free or reduced price drugs to financially needy patients who did not have any type of prescription drug coverage. However, Medicare Part D enrollees will no longer be eligible for these traditional PAPs because they will now have prescription drug coverage. Pharmaceutical manufacturers who want to continue to sponsor PAPs for their low-income patients, who do not necessarily qualify for Medicare's low-income subsidy, have been concerned about the continuation of their PAPs in conjunction with Medicare Part D.

At the request of various pharmaceutical manufacturers, the Office of the Inspector General (the "OIG") of the Department of Health and Human Services issued a Special Advisory Bulletin in November 2005 to address, specifically, whether the anti-kickback statute, which makes it a criminal offense to knowingly and willingly offer, pay, solicit or receive any remuneration to induce or reward the referral or generation of business reimbursable by any Federal health care program, including Medicare (see 42 U.S.C. § 1320a-7b(b)), will be implicated if pharmaceutical manufacturers continue to offer PAPs to financially needy Medicare Part D beneficiaries by helping to subsidize their deductibles.

The OIG acknowledged that pharmaceutical manufacturer PAPs raise a risk of fraud and abuse under the anti-kickback statute because the pharmaceutical manufacturer is giving something of value to the Medicare beneficiaries in exchange for the use of their product. Specifically, if the Medicare beneficiaries use a certain pharmaceutical manufacturer's products, the Medicare beneficiaries may receive a subsidy from the pharmaceutical manufacturer that will count toward the calculation of the Medicare beneficiaries' deductible. (Beneficiaries may count toward their deductible any assistance received from any source other than health plans, insurers and government funded programs.) This type of subsidy to Medicare beneficiaries presents all of the usual risks of fraud and abuse associated with kickbacks including steering beneficiaries to particular drugs, increasing costs to Medicare, providing a financial advantage over competing drugs, and reducing beneficiaries' incentives to locate and use less expensive drugs.

Although the OIG concluded that the traditional pharmaceutical manufacturer PAPs pose a heightened risk of fraud and abuse under the anti-kickback statute, it also recognized the importance of these PAPs, and thus, suggested alternative PAPs in which pharmaceutical manufacturers may continue to participate. First, pharmaceutical manufacturers can make cash donations to bona fide Independent Charity PAPs. This type of PAP raises no real fraud and abuse concerns as long as: (i) the pharmaceutical manufacturer does not exert any control over the charity; (ii) the charity awards assistance in a truly independent manner; (iii) the charity awards assistance based upon a reasonable, verifiable and uniform measure of financial need; and (iv) the pharmaceutical manufacturer does not solicit or receive data from the charity that would help it make some correlation between its donations and the number of subsidized prescriptions for its products. The OIG realizes

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that some charities focus on particular diseases that are treated by particular drugs, and as such, charities focused on particular drugs will generally be acceptable, as long as the charity is focused on the particular disease as a whole, rather than on discrete symptoms of the disease.

Second, pharmaceutical manufacturers may elect to participate in PAPs operating outside of Medicare and provide free drugs to needy enrollees without using the Medicare Part D benefit. This type of PAP goes back to the traditional scope of PAPs and raises no real issue of fraud and abuse, as long as: (i) the PAP has safeguards to ensure that no Medicare Part D payments are being made and no part of the subsidized costs are counted toward the beneficiaries' deductibles; (ii) the PAP provides assistance for the whole coverage year; and (iii) the PAP assistance is based on reasonable, uniform, and consistent measures of financial need and without regard to which Medicare Part D plan beneficiaries are enrolled.

Third, pharmaceutical manufacturers can participate in Coalition PAPs through which multiple pharmaceutical manufacturers would join together to sponsor a single PAP. These PAPs would operate so that the pharmaceutical manufacturers would effectively underwrite their own products. Any risk of fraud and abuse can be reduced if: (i) the PAP has safeguards to ensure that there are no incentives for beneficiaries to favor one particular product; (ii) the PAP includes a large enough number of pharmaceutical manufacturers so any connection between the subsidy and a beneficiary is severed (i.e., the PAP should include competitors and both generic and brand-name pharmaceutical manufacturers); and (iii) each participating pharmaceutical manufacturer offers subsidies for all of its products that are covered by any Part D plan.

Lastly, pharmaceutical manufacturers can participate in Bulk Replacement Model PAPs in which the pharmaceutical manufacturer would provide free drugs directly to the pharmacies, health centers or clinics that dispense drugs to uninsured patients. While this can potentially implicate fraud and abuse issues if the drugs are given to a patient that is in a position to generate federal health care program business for the pharmaceutical manufacturer, i.e. someone who should have enrolled in Medicare Part D, it can avoid these problems by ensuring that there are safeguards in place to: (i) protect beneficiaries from being steered to particular drugs; (ii) protect programs from increased costs; and (iii) ensure that bulk replacement drugs are not improperly charged to Medicare Part D.

In April 2006, the OIG issued a follow up Advisory Opinion in response to a specific request from a pharmaceutical manufacturer regarding a proposed PAP. This proposed PAP would operate outside of Medicare and provide free drugs to needy enrollees without using the Medicare Part D benefit, which is one of the PAPs suggested by the OIG in its November 2005 Bulletin.

In its request, the pharmaceutical manufacturer represented to the OIG that, to qualify for its PAP, patients would not only have to demonstrate financial need, but would also have to be rejected from the Medicare Part D low-income subsidy benefit. The pharmaceutical manufacturer also represented that it would provide assistance without regard to any provider, practitioner, supplier or Part D Plan and that any drugs provided under its PAP would not count as drug expenses incurred by the PAP enrollee and would not count towards the PAP enrollee's Part D deductible.

The pharmaceutical manufacturer further informed the OIG that, once a patient is enrolled in its PAP, the patient will continue to receive assistance for the rest of the coverage year and that the patient's eligibility will be reassessed at the end of that year. Perhaps most importantly, this pharmaceutical manufacturer also informed the OIG that it will not charge Medicare or the patient for any drugs provided under its PAP, that it will maintain records of all drugs provided to Part D enrollees under its PAPs and that it will share this information with the Centers for Medicare and Medicaid Services ("CMS") to ensure that neither Medicare nor any Part D plan pays for the free drugs provided under the PAP.

In light of the information provided by this pharmaceutical manufacturer, the OIG approved its PAP because: (i) the PAP is operating outside of Medicare Part D; (ii) eligibility is determined solely on the enrollee's financial need and not in conjunction with the enrollee's Part D plan choice; and (iii) the assistance under the PAP is provided for a full coverage year. The OIG concluded that these safeguards help lower the risk of fraud of abuse because: (i) the free drugs will not be used to tie Medicare beneficiaries to particular out-patient prescription drugs that are payable by Part D plans; and (ii) the free drugs will not be used to increase costs to Medicare or increase the number of beneficiaries who reach the catastrophic benefit or by inducing enrollees to use higher cost drugs during the catastrophic benefit period.

After the OIG's November 2005 Bulletin, there was a huge concern for the future of pharmaceutical manufacturer's PAPs and whether these PAPs would even continue. In fact, several pharmaceutical manufacturers had said that, because of the heightened risk of fraud and abuse, they would cut patients off from their PAPs if they were enrolled in, or even eligible for, Medicare Part D. Hopefully, in light of the OIG's subsequent approval of the PAP identified in its April 2006 Advisory Opinion, these other pharmaceutical manufacturers will re-

think their decision to cut off this important resource for financially needy patients.

Regardless, the OIG recognizes that the transition to these alternative PAPs will not be without its fair share of problems. Thus, during the first year of the Part D program, the OIG will take into consideration whether a pharmaceutical manufacturer PAP was in existence prior to November 2005 and whether the pharmaceutical manufacturer is taking prompt and reasonable steps to transition patients who enroll in Part D to alternative assistance programs. While the OIG is giving pharmaceutical manufacturers some time to coordinate their new PAPs, pharmaceutical manufacturers should start considering their alternatives immediately and be aware of these potential fraud and abuse implications.

About the Author

Patricia is an associate in Fox Rothschild LLP's corporate department and focuses on the area of health law. Her practice includes counsel on state and federal regulatory and transactional issues, including those implementing the Health Insurance Portability and Accountability Act of 1996 (HIPAA), reimbursement and insurance issues, state licensing requirements, Medicare, Medicaid, certificate of need requirements, and various fraud, abuse and anti-kickback rules.

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Medicare Inpatient Reimbursement to New Jersey Hospitals – Will the Proposed Changes Improve the Diagnosis?

by George Kelley

The Medicare program accounts for close to 50% of inpatient volume for New Jersey hospitals. In aggregate, Medicare reimbursement levels have the potential to significantly impact the financial health of New Jersey hospitals.

The Medicare Inpatient Prospective Payment System (PPS) is about to undergo a significant overhaul in how hospitals are reimbursed for the inpatient services they provide to Medicare beneficiaries. Will these changes correct some of the payment inadequacies in the current system, or continue to perpetuate them?

CBIZ recently conducted a study for a New Jersey hospital client evaluating the profitability of Medicare inpatient cases at New Jersey hospitals. The initial goal of the study was to identify areas of opportunity to improve length of stay and reduce costs to improve profitability. The findings of the study were surprising.

Under the current reimbursement methodology and DRG grouping system, New Jersey hospitals lose $520,000,000 on Medicare inpatient cases when disproportionate share payments (payment for the treatment of low-income patients) are included in the analysis. When disproportionate share payments are removed, the figure jumps to a loss of $754,000,000. Of the 75 New Jersey acute-care hospitals, 16 hospitals generated a profit on Medicare cases. When disproportionate share reimbursement is removed from the equation, only three hospitals were profitable in treating Medicare cases. New Jersey hospitals have gained significant attention over the past few years regarding Medicare outlier cases. Our review of 2004 Medicare outliers shows that all hospitals lost money treating Medicare outlier patients. When the reimbursement change regarding transfers that was expanded in FY 2005 is taken into consideration, the outlook going forward only becomes more dismal.

National media attention generally focuses on New Jersey hospitals as having a longer Medicare length of stay compared to the rest of the nation; our study has found this certainly is the case. One of the goals of the study was to understand how reducing length of stay would increase profitability. Our study indicates that even those hospitals with the lowest Medicare lengths of stay in New Jersey still lost many millions of dollars – we found that Medicare profitability had no correlation with a low length of stay. Only two of the ten lowest case-mix adjusted (CMI) length-of-stay hospitals were among the 16 profitable hospitals. The average CMI adjusted length of stay for the 16 hospitals was approximately 4.23 which is effectively the same as the New Jersey average of 4.42. If cost is to be utilized as a measure of efficiency, only two of the ten hospitals with the lowest cost per case were among the 16 profitable hospitals. When these figures are adjusted for case mix variation, three of the ten hospitals with the lowest cost per case were included in the 16 most profitable hospitals. When the New Jersey hospitals were ranked we found that on average the 16 profitable hospitals ranked 34th for average length of stay and 31st for cost per case, just about in the middle of the group. Profitable hospitals as a group were neither low cost nor low length of stay. A quick conclusion of the study findings would indicate that cost and length of stay are not the sole determinants of Medicare profitability, so what are the factors?

The reasons for profitability of the 16 hospitals were not related to the efficiencies of the hospitals reviewed. Our study found the following elements contributing to a positive bottom line:

• DSH Payments – Disproportionate Share (DSH) payments are additional dollars provided by Medicare for the treatment of a Hospital's indigent population. These funds are provided to hospitals for the treatment of indigent cases, not Medicare beneficiaries.

• IME Payments – Indirect Medical Education payments are additional payments provided to teaching hospitals to cover the increased costs associate with teaching programs.

•Wage Index Adjustment – The Wage Index is an adjustment to the standard Medicare PPS rates to address regional salary differences.

These Medicare add-on payments generate the positive bottom line for Medicare cases in New Jersey. The payments are designed to compensate hospitals for the cost of treating indigent patients, administering a teaching program and adjusting for the higher cost of labor in our area. The fact that the add-on payments are the reason for profitability highlights the inadequacy of the Medicare rates for New Jersey hospitals.

Although there may be opportunities for specific hospitals to marginally improve their operational efficiency through improved medical management, these opportunities cannot compensate for the inadequacy of the current Medicare rates.

There may be some light or some relief at the end of the tunnel.

Part of the argument of the New Jersey hospital industry is the intensity of the patients it treats. Some of the changes that the Medicare program is considering have the potential to significantly increase the weight in which intensity and severity of hospital case mix have on Medicare reimbursement levels for inpatient stays.

The proposed rule for Fiscal Year 2007 of the Medicare Inpatient Prospective Payment System was published in the Federal Register on April 25, 2006. The goal of the proposed changes is to fine tune the DRG system to better address severity of illness. This is to be accomplished with a two-step process:

Step 1 - Limited changes to the DRG classifications as well as revisions to the DRG weights. The DRG weights are proposed to be calculated based on cost-based Hospital Specific Relative Values (HSRVs) versus charge-based HSRVs. This process will affect the FY 2007 payment rates.

Step 2 - Institute a DRG grouping methodology that employs severity adjustment. This change will take place by FY 2008 if not sooner.

Based on our review of the proposed rule, we are finding that the change in the relative weights is skewing more reimbursement to medical DRGs and away from surgical DRGs. This will benefit some hospitals in the state, possibly at the expense of others. This first step will redistribute Medicare payments between hospitals, but most likely will not correct the issue of a more intense case mix overall.

Our hope lies in the second step, the institution of a severity-based DRG payment system. The example listed below demonstrates the drastic difference between the current DRG assignment and the ARP-DRG assignment:

	CASE	CASE II
PRINCIPAL DIAGNOSIS	CONGESTIVE HEART FAILURE	CONGESTIVE HEART FAILURE
Secondary Diagnosis	Chronic Obstructive Pulmonary Disease Artrial Fibrillation	Chronic Obstructive Pulmonary Disease Atrial Fibrillation Respiratory Failure Acidosis Malnutrition Cardiogenic Shock
Medicare DRG	127 Heart Failure and Shock	127 Heart Failure and Shock
APR - DRG	194 Heart Failure	194 Heart Failure
APR - DRG Severity of Illness	2 Moderate	4 Extreme
APR - DRG Risk of Mortality	1 Minor	4 Extreme
Medicare Relative DRG Weight	1.0039	1.0039
APR - DRG relative Weight	0.7930	3.0052

In the example presented above, both "Case I" and "Case II" map to the same DRG in both the current DRG system and the APR-DRG system. However, under the APR-DRG system, severity and mortality are also considered in the calculation of reimbursement. "Case II" under the APR-DRG system has a much higher weight due to a severity of four (4) and a mortality of four (4). Assuming a base rate of $3,500, under the current system the hospital will be reimbursed $2,775 for DRG 127 – Heart Failure and Shock with a relative weight of .7930. Under the APR-DRG system the case would be reimbursed $10,518 for APR-DRG 194 – Heart Failure with a severity of four (4) and mortality risk of four (4). The proposed system takes into account the complications and comorbidities listed above that impact severity and drive the cost of care.

This example illustrates the power of the severity adjustment under the proposed methodology. Sicker, more severe cases would be reimbursed at a much higher rate.

CBIZ is currently in the process of working with the data to establish the impact of the severity enhanced grouper on the overall reimbursement picture for New Jersey hospitals. We are hopeful that this change will improve the reimbursement outlook but it does not ensure that Medicare rates will adequately reimburse New Jersey hospitals. Part II – an analysis of the overall impact of the severity enhanced DRGs will be presented in the next issue of FOCUS.

For more information, please contact George Kelley, Executive Director of CBIZ KA Consulting Services, LLC at 609.918.0990 x 125.

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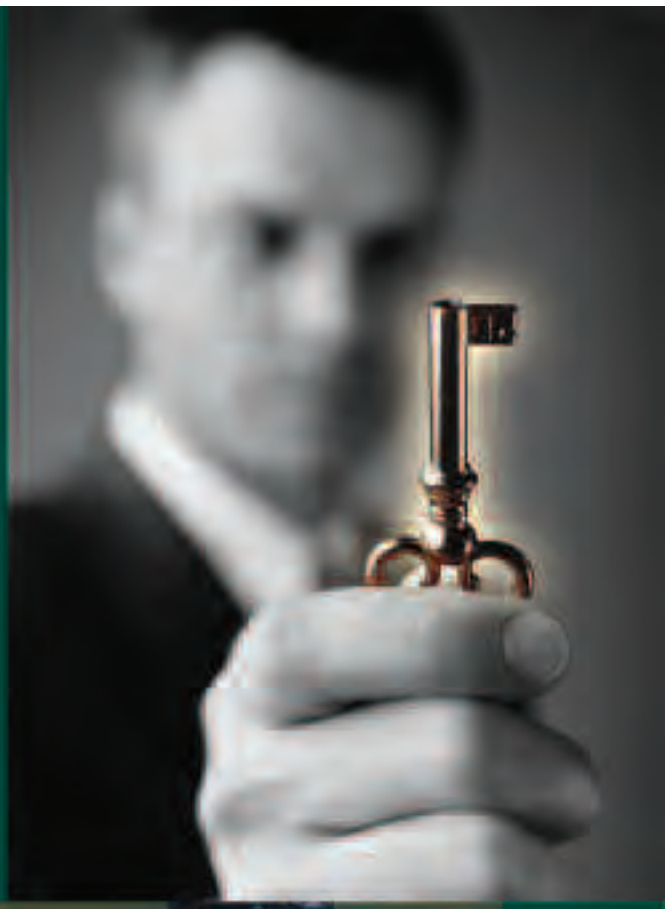

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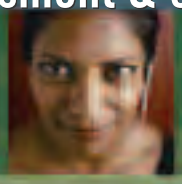

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September 27, 2006

Cranbury Golf Club

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September 27, 2006	all day	Women's Initiative & Golf Outing	Cranbury Golf Club
October 11-13, 2006		NJ HFMA Annual Institute	Borgata, Atlantic City
January 9, 2007	all day	Quarterly Meeting – PFS and Pt. Access Committees, NJAAHAM	Woodbridge Hilton
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