The HFMA Founders Merit Award Program

Submitted by Gerri Provost, FHFMA, Certification Committee

As the 2011-2012 HFMA Chapter year ends and the new 2012-2013 Chapter year begins, it is important to ensure that all Founders points earned by our members are accurately recorded. Our Chapter is committed to “Recognizing the Volunteer in You”.

Since much of the collecting and recording of Founders points happens “automatically”, i.e. without the member’s involvement in the process, the question “what are Founders points” is a common one when an individual sees his/her name on a Founder’s points list.

The Certification Committee would like to provide some insight…

Recognizing the strength and value of its volunteers, HFMA strongly encourages continuous active “volunteer” participation at the local, regional and national levels. Accordingly, a point system and award levels are in place to formally reward members for their contributions of time, ideas and energy, expended to not only HFMA but to the healthcare community and to one another.

In addition to Founders points awarded to those individuals in HFMA leadership roles, points are awarded to member participants on Chapter committees, event volunteers, article authors and speakers at HFMA programs. Amy Vaughan, Secretary, is the current Chapter’s Founders Award chairperson. Recently, all committee chairpersons were asked to submit the names and Founders points earned for the members on their committees during the 2011-2012 Chapter year. Amy will compile all the points and report them to National.

Various levels of recognition are given to individuals for their “outstanding service to members” for their significant contributions to HFMA, as evidenced by Founders points earned. The Founders Merit Award Series consists of 4 award levels:

- Follmer Bronze Award (25 member points)
- Reeves Silver Award (50 member points)
- Muncie Gold Award (75 member points)
- Founders Medal of Honor (not based on the point system; a member must have a minimum of 3 years of service after earning the Muncie Gold Award; nominations are made by the Chapters and submitted to National)

Once earning the Certified Healthcare Financial Professional (CHFP) designation an HFMA member can achieve the designation of Fellow of the Healthcare Financial Management Association (FHFMA) after meeting additional requirements. Performance of volunteer activity is one of the requirements to achieve FHFMA designation; earning the Follmer Bronze Award satisfies this requirement.

Take a moment now and view your Founders points on the HFMA National website under Manage My Account in your personal profile. This record of your involvement will remind you of your past volunteerism and the numerous opportunities available through HFMA for professional development, networking and personal growth, as you consider the details of your involvement in Chapter

(Continued on page 6)
When I was driving in to the office this morning, a sports announcer took the opportunity to remind Red Sox Nation that while the Red Sox are currently 8-10 and that appears to be pretty poor performance, a year ago at the same time they were 10-13 and they made it to the playoffs so we should not yet lose heart. Knowing that this, my last President’s Message, was on my plate this morning, the announcer caused me to pause and reflect on the HFMA Chapter Year coming to a close on May 31. As the Leadership Team reviewed the Chapter Balanced Scorecard at a recent board meeting and again at HFMA’s National Leadership Training Conference (LTC), the picture is pretty bleak. We failed to meet the goals set by National for the chapter in education and member satisfaction, and we are perilously close to not making goals with respect to membership and days cash on hand. If we miss all four of these standards, we are deemed to be a Chapter in need of improvement. While this is not a positive message, I would say these numbers do not truly reflect the year this Chapter has had with respect to some goals the leadership set a year ago so I would like to take the remainder of this President’s Message to share some of the achievements of this year.

For the last several years, the leadership has been concerned about succession planning and a need to develop new leadership within the membership. I am pleased to share with you that as we move into the 2012-13 Chapter Year we have a number of members stepping up into leadership. Val Barbour will be co-chairing the Scholarship Committee, Peter Smith will be co-Chairing the Certification Committee, Eric Walker will be leading the Newsletter Committee, and Amy Beth Main will continue leading the Sponsorship Committee. These folks have all been identified as new leadership and when approached have been willing to step up. They bring new enthusiasm and energy, and we look forward to their joining with the existing leaders to take the chapter forward with a number of new initiatives. In addition, they are identifying and building committees incorporating a number of other new members and seeking to reincorporate some of our past leaders to achieve that balance of wisdom and experience with energy and enthusiasm.

Similarly, we set out this year to increase the number of members actively involved in volunteering in the Chapter this year. You will recall that my last message after the Annual Meeting in March was focused on volunteerism and our success in this area having identified well over 30 members with Certificates of Appreciation for Volunteer Involvement with three members recognized as going above and beyond with their volunteer efforts.

The Chapter has also been challenged in recent years with achieving adequate scores in member satisfaction and much of that challenge has been related to our education programming. The challenges range from locations of programming and quality of topics and speakers. A number of modifications have been made to our approach to education over the last two years including increased use of webinars and most recently the use of video-conferencing so members have the opportunity to attend a session in one of two locations that are tied together with technology. As we have overcome the challenges of moving forward in the electronic medium of producing education, we are finding more opportunities and increased satisfaction by our members. As the 2012-13 Education Planning is done in early May, the intent is to continue moving some of these initiatives forward with some tweaking of existing approaches and seeing what other opportunities we have at our disposal. With respect to speakers, a Speaker’s Bureau is being developed that will engage members, sponsors, and provider leadership as speakers in the year ahead.

Sponsorship is the third area where we have focused a great deal of energy this past year with significant success. We have modified our Sponsor year to reflect the budget years and needs of our sponsors and we have increased opportunities for sponsorship by developing some event specific sponsorship. As we have rolled out some of these opportunities, we have been successful in generating further interest in annual sponsorship as well. We have, in fact, successfully recruited a number of annual sponsors and encouraging a number of sponsors to move to higher sponsorship levels. We have a full Sponsorship Committee moving into 2012-13 and expect to see continued success in this area.

While these areas of success are not reflected on our Balanced Scorecard, we truly are encouraged by the forward momentum generated in these areas. You will find, later in this newsletter, an overview of the Chapter Balanced Scorecard and we will be spending time in each newsletter next year focusing on the measures that National includes and how they establish the goals for the Chapter.

As I close my year, I want to thank all of our members for their engagement with the Chapter and want to encourage you all to find the place where you can both serve in and be served by our Chapter in the days ahead.

Thank you!

Evalie M. Crosby
Chapter President
Certification and the Larger Career Picture...This is a Pop Quiz!

Do you know the requirements or mechanics to take the certification exam? You have 2 minutes to finish, NO searching the website for the answers and find out if you are the ideal candidate for the new testing structure.

1. The ideal certification candidate is an active HFMA member and has
   a. Industry experience
   b. Management experience in the industry
   c. 3-5 years management experience including financial responsibilities in a healthcare provider organization
   d. Management experience and a finance background

2. The certification program assesses knowledge and skill in six domains: revenue cycle, disbursements, budgeting & forecasting, internal control, financial reporting, and contract management. The three major areas of focus are:
   a. Revenue cycle, budgeting & forecasting, and disbursements
   b. Revenue cycle, budgeting & forecasting, and financial reporting
   c. Revenue cycle, budgeting & forecasting, and internal controls
   d. Revenue cycle, budgeting & forecasting, and contract management

3. The certification preparation materials are
   a. Available online through HFMA's website
   b. Required for certification
   c. Free to candidates
   d. Now approved by CAHME

4. Chapters can provide key support to candidates by providing a certification “coaching” course. A chapter coaching course
   a. Should be developed by knowledgeable people in the chapter
   b. Is now required by the Chapter Balanced Scorecard
   c. Must be reviewed and approved
   d. Is available for chapter use, free of charge

5. Quality chapter coaching courses
   a. Must focus only on teaching self-study content
   b. Demand an experienced instructor
   c. Should have limited enrollment
   d. Encourage exploration, dialogue, and reasoning out appropriate solutions

6. HFMA certification requires the successful completion of
   a. One comprehensive exam
   b. A core exam and a specialty exam
   c. One comprehensive exam and 15 hours of volunteer service
   d. A core exam and a specialty exam and 15 hours of volunteer service

7. Upon successful completion of the exam requirements, the candidate
   a. Should send in the CHFP application and requisite fee
   b. Begin the 15 hours of required volunteer service before sending the application
   c. Must inform the Chapter President so that the President sends in the “Member in Good Standing” form
   d. Is automatically awarded certification and may use the CHFP designation

8. The chapter will receive a list of newly certified members
   a. Weekly
   b. Monthly
   c. Semi-annually
   d. Annually

9. The certification maintenance requirement is
   a. 30 hours per year average; ½ in healthcare finance
   b. 45 hours in two years; ½ in healthcare finance
   c. 60 hours in three years; ½ in healthcare finance
   d. 90 hours in three years; ½ in healthcare finance

Answers:
Has the Medicare Cost Report Become Relevant Again?

Submitted by Scott Besler

In the present environment, as hospitals compete for business, whether it is for patients or physicians or third party payors, the Medicare Cost Report is becoming a useful benchmark for senior leadership.

Medicare Cost Report Defined

Providers that participate in the Medicare program must submit an annual Medicare Cost Report (MCR) to their Medicare Administrative Contractor (MAC) also known as their Fiscal Intermediary (FI). The MCR is a rather large financial report of various data. The MCR includes certain data related to patient statistics (e.g., visits, discharges, and days), provider’s total gross and net revenue, and expenses. A provider’s payer mix (i.e., amount of Medicare and Medicaid, as well as commercial and private third party payer, patients) is also included and is an important part of the MCR. This data is submitted and separated by hospital services. The MCR determines each provider’s total costs and charges that are associated with all patients, and allocates a portion of these costs and charges to Medicare patients. The amount is then compared to the payments received by the provider from Medicare and a settlement is then calculated. From this streamlined perspective, the MCR has been compared to a tax return.


The MCR is divided into worksheets which allow for the correct submission and flow of the report and also make it easy to compare data elements among providers and between cost reporting years.

Below is a brief description of the most common worksheets.

<table>
<thead>
<tr>
<th>Worksheet</th>
<th>Description</th>
<th>Purpose/Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>S Series</td>
<td>Statistical data</td>
<td>To properly report statistics related to payer</td>
</tr>
<tr>
<td>A Series</td>
<td>Proper classification of expenses by cost center</td>
<td>To report allowable Medicare costs by cost center or department</td>
</tr>
<tr>
<td>B Series</td>
<td>Matching of costs to revenue by utilization of a step-down approach</td>
<td>Allocation of overhead costs</td>
</tr>
<tr>
<td>C Series</td>
<td>Matching of cost to revenue – gross revenue by cost center or department</td>
<td>Calculation of cost-to-charge ratios</td>
</tr>
<tr>
<td>D Series</td>
<td>Calculation of Medicare share of hospital cost</td>
<td>Determine a hospital’s portion of Medicare cost</td>
</tr>
<tr>
<td>E Series</td>
<td>Calculation of Medicare settlement</td>
<td>Determine amount owed by or owed to the Medicare program</td>
</tr>
<tr>
<td>G Series</td>
<td>Hospitals Financial Statements</td>
<td>Report the financial statements into the cost report software</td>
</tr>
</tbody>
</table>

There may be other worksheets that a hospital is required to submit due to the type of services provided. For example, providers that offer renal services will have to complete the I series worksheets, and those that offer provider-based services for Hospice and Home Health will need to submit the H and J series worksheets, respectively.

Worksheet S-10

The Centers for Medicare and Medicaid Services (CMS) has made several changes to the Hospital Cost Report data system, and the new CMS-2552-10, after having a few minor snags, is in full use. Of the many changes, no worksheet has seen more change than worksheet S-10 – Hospital Uncompensated and Indigent Care Data.

The purpose of worksheet S-10 is to provide charges and payments for uncompensated care and indigent care and to calculate the associated cost for providing patient care services for which the hospital is not compensated. Hospitals will utilize several data elements, including but not limited to the following:

- Uncompensated Care Policies;
- Bad debt listing by write-off date applicable to cost reporting period;
- Charity care listing based on service date with the cost reporting period;
- Medicaid traditional and managed care listing including patient charges and payments; and
- Documentation to support Disproportionate share (DSH) or supplemental payments for Medicaid (State subsidy funding)

There are three major components of worksheet S-10:

- **Uncompensated Care**
  Listed as charity care but also the bad debt which would include both non-Medicare bad debt and non-reimbursable Medicare bad debt.
  **Note:** Uncompensated care does not include courtesy allowances or discounts given to patients.

- **Charity Care**
  Includes all health services at the hospital where it was demonstrated that the patient is unable to pay. Charity care results from a hospital’s policy to provide all or a portion of services free of charge to patients who meet certain financial criteria.
  **Note:** For Medicare purposes, charity care is not reimbursable and unpaid amounts associated with charity care are not considered as an allowable Medicare bad debt.

- **Bad Debt**
  This is the provision for actual or expected uncollectible accounts. Bad debts that would be included are those that are non-Medicare patients and those that are non-reimbursable Medicare Bad Debt.

   (Continued on next page)
HIGHLIGHTS OF THE OIG SEMIANNUAL REPORT (SPRING 2012)

Summary of Accomplishments

For the first half of FY 2012, the OIG reported expected recoveries of about $1.2 billion consisting of $483.1 million in audit receivables and $748 million in investigative receivables (which includes $136.6 million in non-HHS investigative receivables resulting from their work in areas such as the States’ shares of Medicaid restitution).

The OIG reported exclusions of 1,264 individuals and entities from participation in Federal health care programs; 388 criminal actions against individuals or entities that engaged in crimes against HHS programs; and 164 civil actions, which include false claims and unjust-enrichment lawsuits filed in Federal district court, civil monetary penalties (CMP) settlements, and administrative recoveries related to provider self-disclosure matters. Following are highlights of some of the significant problems, abuses, deficiencies, activities, and investigative outcomes that are included in the Semiannual Report for the first half of FY 2012.

Health Care Fraud Prevention and Enforcement Action Team

Medicare Strike Force Teams

Medicare Fraud Strike Force teams coordinate law enforcement operations conducted jointly by Federal, State, and local law enforcement entities. These teams, now a key component of HEAT, have a record of successfully analyzing data to quickly identify and prosecute fraud. The Strike Force began in March 2007 and is operating in nine major cities. The effectiveness of the Strike Force model is enhanced by interagency collaboration.

• Strike Force Accomplishments – During this semiannual period, Strike Force efforts resulted in the filing of charges against 101 individuals or entities, 96 criminal actions, and $50.9 million in investigative receivables.

• Arrests in the Northern District of Texas – A physician and the office manager of his medical practice, along with five owners of home health agencies, were arrested February 28 on charges related to their alleged participation in a nearly $375 million scheme involving fraudulent claims for home health services. The conduct charged in this indictment represents the single largest fraud amount orchestrated by one doctor in the history of HEAT and our Medicare Fraud Strike Force operations and the largest alleged home health fraud scheme ever committed. As a related matter, CMS announced the suspension of 78 home health agencies (HHA) associated with the physician based on credible allegations of fraud against them.

Strike Force Investigation Nests Imprisonment, $6 Million in Restitution in Infusion and Injection Therapy Scheme

Clara Guilarte Caridad Guilarte, along with previously captured and sentenced co-conspirator Reynel Betancourt, submitted $9.1 million in false and fraudulent claims. The trio recruited and paid cash and other inducements to Medicare beneficiaries to visit the Dearborn Medical Rehabilitation Center (DMRC), which the Guilartes owned and operated, and sign forms indicating that they received legitimate medical services, including injections and infusions of expensive medications that were not actually provided. The Guilartes then distributed medications that were not actually provided. The Guilartes were arrested February 28 on charges related to their alleged participation in a nearly $375 million scheme involving fraudulent claims for home health services. The conduct charged in this indictment represents the single largest fraud amount orchestrated by one doctor in the history of HEAT and our Medicare Fraud Strike Force operations and the largest alleged home health fraud scheme ever committed. As a related matter, CMS announced the suspension of 78 home health agencies (HHA) associated with the physician based on credible allegations of fraud against them.

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The United States Supreme Court recently heard cases challenging the constitutionality of certain provisions of the Patient Protection and Affordable Care Act, leaving the fate of the healthcare reform law in question. If the act’s individual mandate is struck down by the Court, it is uncertain what portions of the law, if any (including the DSH changes), will survive.

The provider community has withstood similar changes to the cost reporting requirements in the past. The use and importance of cost report data for Medicare Inpatient and Outpatient Prospective Payment Systems, will continue to be an important piece of hospitals’ future plans. Hospital leadership needs to be aware of various re-opening and appeal processes. For many hospitals, having a proactive plan in place can result in witnessing increased revenue through corrected payments, which has helped them to meet their fiscal responsibilities and their social missions.
The HFMA Founders Merit Award Program...(Cont.)

activities this year. And see how close you are to achieving the next level of Founders Merit Awards!

Although most points are reported to the Chapter’s Founders Award chairperson by committee chairs, it is the responsibility of each member to ensure all points have been reported. All members were recently sent an e-mail, requesting them to review their Founders points. E-mail Amy Vaughan at Amy.Vaughan@vtmednet.org all points earned in the 2011-2012 Chapter year which were outside of Chapter committee involvement, such as volunteer activities at the Regional and/or National level as well as any concerns relating to the recording of your Founders points, on or before June 22, 2012.

Summer is upon us...
The 2012 Vermont legislative session ended at 6:42 pm on Saturday, May 5th. While lawmakers celebrated, stakeholders around the state were already thinking about how to manage the directives set in motion by the newly created laws. In addition, the Green Mountain Care Board (GMCB) continues to gain steam. This independent board has become a major focus of VAHHS’ attention, especially as they look for ways to incorporate the broad aims of Act 48 of 2011 (like containing costs, improving quality of care and improving the health of the population) into the regulatory powers they now wield.

Out of this session came two major health care laws, Act 79 (H.630) related to the replacement of the Vermont State Hospital and Act 171 (H.559) the implementation of the Vermont health benefit exchange. VAHHS has identified 20 separate advisory committees, work groups, reports, studies and proposed rules to track, participate and comment on in the coming months. One area of concern in Act 171 is the provision for the development of the basic health plan. Under this provision, states have the option to provide a health insurance product outside the health benefit exchange to individuals between 133% and 200% of the federal poverty level. VAHHS strongly opposes the basic health plan concept because it would effectively function as an expansion of Medicaid.

In late May, the GMCB has heard testimony on hospital finance and health care reform from a panel of Vermont hospital CEOs and from one of the state’s consultants on payment reform. Bob Murray from Global Health Payments set the stage for the discussion by recounting the “Maryland experience” to describe how hospitals migrated from fee for service payments to total revenue budgets. Bob Murray and the hospital panel emphasized the importance of financial sustainability as hospitals take on new reform-related challenges. Panelists also stated that reform created “tremendous opportunity” to change the delivery of health care. They added that without delivery system changes, better coordination and collaboration among providers, health reform would fail. More specifically, panelists explained the need for a strong balance sheet to support both new reform efforts and current care needs. Hospital CEOs provided specific examples of challenges they face balancing their efforts to advance reforms and stay financially solvent. In addition, costs, such as physician salaries, must remain nationally competitive. Given the complexity of payment and delivery system reform efforts, VAHHS anticipates that similar conversations with the GMCB will be in order!

Health care reform continues to be at or near the top of both the federal and state agendas. What used to be the least busy time of year has become a “second season” of activity, meetings, reports and advocacy. Check the www.vahhs.org website for the latest on these developing issues.
Certified Revenue Cycle Representative (CRCR) Program

You may have seen it in National newsletters...effective September 1, 2011, the CRCR Program was moved from a credentialed program to a CRCR designation, an exam proctored electronically and monitored by HFMA with an online study guide.

The Credentialed Revenue Cycle Representative program educates and recognizes healthcare workers who have attained an accepted standard of knowledge and proficiency in the revenue cycle. People meeting the requirements of the program earn the CRCR designation. The designation proves a high level of revenue cycle knowledge and expertise has been reached.

Who Should Become Certified?
This program is recommended for hospital revenue cycle staff and associated departments. This includes, but it is not limited to:

- Patient Access
- Patient Accounts / Billing
- Health Information Management
- Case Management
- Compliance / Decision Support
- Finance
- Financial Counselors
- Managed Care Contracting & Operations

What are the requirements for CRCR maintenance?
At the successful completion of the program, HFMA members and non-members will be certified in the CRCR program. The initial exam is 150 questions, which includes topics in:

- Compliance
- Patient access
- Claims processing
- Account resolution
- Cash
- Financial management and
- Support departments

The HFMA members and non-members who earned the designation must recertify every two years by retaking a 75 question exam. These candidates will be allowed 90 minutes for the CRCR retake exam with a recertification fee of $150. Both the study course and online exam are supported by HFMA and individuals as well as organizations may purchase this program.

Why not put the CRCR program to work for you?
The value to your organization will be improving financial performance by raising the revenue cycle staff knowledge, measuring staff proficiency, recognizing staff knowledge and expertise, increasing inter-departmental satisfaction and staff competency that ensures quality work.

To learn more about the new program, contact your Certification committee or see additional information online and FAQ’s at www.hfma.org/crcr.
FREE Certification Webinars
Recorded and at your convenience!

If you have missed the past two On-Line Certification Study Groups, here is your opportunity to participate! Four chapters, WI, McMahon Illini, NH/VT, and VA/DC have collaborated to find knowledgeable speakers to present the certification material. A number of our On-line Certification Study Group members told us that they would appreciate a high level review of the six certification modules. A one hour session has been recorded for each module:

1. Revenue Cycle - presented by Randy Bledsoe (VA/DC)
2. Disbursements - presented by Kathleen Beriau (NH/VT)
3. Budgeting/Forecasting - presented by Jane Kapoian (NH/VT)
4. Internal Controls - presented by Connie Ouellette (NH/VT)
5. Financial Reporting - presented by Christina Bradbury (NH/VT)
6. Contract Management - presented by Mike Newby (VA/DC)

The sessions are available on our website. You’ll be asked to register, and when you submit the registration, you’ll be directed into the recorded presentation. This educational time counts towards your CEUs and your registration adds to our education hours for the NH/VT chapter leader’s scorecard.

To Access the Pre-Recorded Webinars (follow these steps):

1. www.NHVTHFMA.org
2. Certification (on left hand side of page)
3. Certification Coaching Sessions (4th option listed under Certification)

The NH/VT Chapter maintains a high percentage of certified members (14% of our members), and we would like to add your name to our list. Validate your skills and knowledge and support your professional development....becoming certified distinguishes you as a leader and role model in the healthcare finance field.

For more information about the certification material and information about the different exams, contact Diane Blaha, our Certification Chair, at diane.blaha@gmail.com.
2012 Education Calendar and Webinars

Submitted by Diane Blaha

We originally planned for March 2012 to have a webinar on the Medicaid Integrity Contractors. Presently, the contractor details are not clearly defined and we are replacing this webinar with pre-recorded webinars. They are available to you and filed on our website.

The topics are:

1. Contracting Lessons Learned from Denials Management
   - Presented by Robin Fisk, Principal of Fisk Law Office

2. Denials Management (and best practices)
   - Presented by Maggie Fortin, Senior Manager from Baker Newman Noyes

3. Drugs, Self Administered and Best Practices for Payment
   - Presented by Leslie Haddy, PFS Supervisor at Memorial Hospital

The webinars are located on the NH/VT chapter’s website and the access steps are:
1. www.NHVTHFMA.org
2. Education & Events (on left hand side of page)
3. Recorded Webinars (listed under Education & Events)
4. Pre-recorded Webinars

This is an education opportunity in addition to the live recordings from the January/February 2012 webinar series for our chapter. It’s a free educational opportunity for our members in the convenience of your home or at your desk during lunch hour.

Consider this a great combination of earning your CEU’s and keeping up-to-date on changes in your career!

C O N G R A T U L A T I O N S ! ! !

Congratulations for her advancement to Fellowship status.
We are pleased to recognize her volunteer efforts and advancement from CHFP to FHFMA to:

Robin Fisk, FHFMA - Fisk Law Office

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experience reach

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ANNUAL MEETING
New Member Profile – David Brace

Submitted by Amy Vaughan, Fletcher Allen Health Care

We’d like to welcome David Brace to our Chapter. David is the Chief Financial Officer of Community Health Services of Lamoille Valley since February 2012. Prior to joining Community Health Services of Lamoille Valley, David was a Public Accountant specializing in the non-profit sector.

When David was asked what he enjoys most about his work, he stated: “I am committed to community involvement and am passionate about the medical and dental services that our not-for-profit organization provides to our community”.

David stated that some of the different healthcare issues that he deals with are: Preparing for changes in payment reform; changes to a quality-based outcome measurements and how it is used in evaluating payments for services. In addition to this, David feels that the biggest challenge over the next 12-24 months is to leverage Information Technology, and reducing costs.

David joined HFMA to stay current on information and creating a healthcare network of financial managers. David is a Certified Public Accountant with an MBA with a concentration in International Business.
Looking to Network with Someone?

Have you visited HFMA’s Online Membership Directory lately? Log in at http://www.hfma.org/login/index.cfm. When you select “HFMA Directory,” not only can you search for members of your chapter, you can also search for all your HFMA colleagues by name, company, and location—regardless of chapter! Using an online directory instead of a printed directory ensures that you always have the most up-to-date contact information.

While accessing HFMA’s Online Membership Directory, you can view your current contact information and make edits to your profile. You can also see products you have ordered, events you have registered for, your CPE credits, your Founders points, and more!

It’s vital that HFMA has your correct information, so please take a moment to review your record now. By doing so, you’ll ensure that HFMA continues to provide you with valuable information and insights that further your success.
FREE Summer Webinars!

Looking for a convenient way to earn CPEs over the summer between trips to the beach and weekend get-a-ways? Check out hfma.org/webinars to see the listing of FREE webinars for members!

JUNE
Using HFMA’s MAP App to Improve Practice Management
June 13: In this complimentary webinar, you will learn about key areas where your physician practices need to focus and ways to better track revenue cycle performance, identify problems and implement solutions in the practice setting. You will also learn how to recognize where improvement efforts are likely to offer the best payoff, based on benchmarking data from the MAP App.

Artificial Intelligence (AI): The Future of the Supply Chain**
June 14: After this webinar, you will be able to understand how strategic sourcing tools with built-in AI provide the accurate data needed to support value analysis and standardization efforts.

Dealing with converging regulatory challenges of MU II, RAC, ACO & ICD-10
June 19: After this webinar, you will be able to assess the current status of your clinical documentation solutions; learn to address challenges with improved clinical documentation quality to enhance all aspects of the revenue cycle through improved RAC preparation, remediation and collaboration; and understand the role of technology solutions to increase your clinical documentation quality, provide actionable intelligence and support your complex workflows.

Using Business Intelligence to Understand Financial Impact of Clinical Quality
June 20: After this webinar, you will be able to understand the clinical quality events that the government and regulatory agencies have required organizations to report; identify the relationship between quality events and increased cost without increased revenue; and learn how to meld clinical and financial data into one enterprise-wide data warehouse for reporting and analysis.

JULY
Preparing for the Future: The Value of Integrating Physician Practice Data
July 26: After this webinar, you will be able to centralize and integrate physician practice data with the hospital’s core analytics system; strengthen user understanding and practical applications of that data; and use predictive modeling tools to model future payment structures.

AUGUST
How to Control Costly Physician Preference Items**
August 23: After this webinar, you will be able to capture all supplies outside the official MMIS to gain visibility and control of costly PPI.
Healthcare Financial Management Association (HFMA) released an issue analysis called MEDICARE INCENTIVE PAYMENTS FOR MEANINGFUL USE OF ELECTRONIC HEALTH RECORDS: Accounting and Reporting Developments in December 2011. HFMA through its Principles and Practices (P&P) Board publishes issue analyses to provide short-term practical assistance on emerging issues in healthcare financial management. To expedite information to the industry, issues analyses are not sent out for public comment. Therefore, they are factual, but not authoritative. The following is a summary of that article to highlight the methods for which reporting incentive payments as revenue can be recognized.

The American Recovery and Reinvestment Act of 2009 (ARRA) established incentive payments under the Medicare and Medicaid programs for certain professionals and hospitals that “meaningfully use” certified electronic health record (EHR) technology. The Centers for Medicare & Medicaid Services (CMS) chose to take a phased approach to defining meaningful use (through three stages), using criteria that become more stringent over time.

Generally, it appears that hospitals receiving Medicare incentive payments have accounted for them using either a contingency model or an IAS 20 grant accounting model. Although the Securities and Exchange Commission (SEC) had not issued any formal views on EHR income recognition at the time this paper was published, preliminary indications are that SEC registrant hospitals are applying a contingency model. Other hospitals—i.e., those that are privately-held, not-for-profit, or governmental—appear to be choosing between the two models as a matter of accounting policy.

Contingency Model

A key consideration in applying the contingency model is appropriately identifying the contingencies that must be satisfied prior to recognizing the revenue. The contingency model would not permit income from incentive payments to be recognized until the hospital has actually complied with the meaningful use criteria for the full EHR reporting period in a given year. Under the contingency model, the income from the incentive payments would be recorded entirely in the period in which the last remaining contingency is resolved.

IAS 20 Grant Accounting Model

IAS 20, paragraph 7, notes that “Government grants... shall not be recognized until there is reasonable assurance that (a) the entity will comply with the conditions attaching to them; and (b) the grants will be received.”

An entity may estimate the income associated with EHR incentive payments. Page 44450 of the Federal Register states the following related to the incentive payment formula: “Congress deliberately chose to limit incentive payments based on the statutory formula [emphasis added]...and further limited the amount of incentive payments available to large hospitals by not increasing incentive payments above 23,000 discharges.” As the grant amount is determined based on a formula, and as that formula includes inputs that may not be known by the entity at the time of recognition (e.g., total discharges, charity charges), the entity should make estimates of those inputs to determine how much should be recognized in income.

IAS 20, paragraph 27, states that “Grants related to income are sometimes presented as a credit in the statement of comprehensive income, either separately or under a general heading such as ‘Other income,’ alternatively, they are deducted in reporting the related expense.” It would not be appropriate to report grant income from the EHR incentive payments as an offset of expense, as the payments are not earned as a result of reimbursing specific expenses incurred in specific periods. Instead, the grant should be displayed as income, either presented separately or included in a caption such as “other income,” depending on the hospital’s facts and circumstances.

To meet the IAS 20 objectives for disclosures, it would be appropriate for all hospitals (nongovernmental and governmental) to disclose the following information:

A) The recognition policy applied to grant income, including the method of recognition of grant income relating to the incentive payments (cliff or ratable recognition) and the location of the grant income in the statement of comprehensive income, if not apparent from details disclosed on the face of the statement.

B) A general description of the incentive program, including the nature of the incentive payments, how the incentive payments are calculated, and the attestation process.

C) A discussion of the fact that the amount of grant income recognized is based on management’s best estimate and that amounts recognized are subject to change, with such changes impacting operations in the period in which they occur. The hospital typically would disclose the nature of and amount of material changes in accounting estimate relating to grant income. In addition, the hospital would disclose the fact that its attestation is subject to audit by the federal government or its designee.

The extent of disclosure would be dictated by the materiality of the incentive payments to an individual hospital (or health system).

The entire article from HFMA can be found at: http://www.hfma.org/EHRPayments/ and is worth reading in it’s entirety to ensure proper understanding of the guidance. Also, many examples are in the article that show how revenue would be recognized under the different methods. A major benefit to using the grant model over the contingency model is that revenue can be recognized over the attestation period instead of in lump sums when received. Many hospitals may receive a payment in year one, no payment in the year two, and then receive a payment again in year three.

Eric is the Director of Accounting at Catholic Medical Center in Manchester, New Hampshire. Any questions or comments regarding this or other topics can be emailed to Eric at ewalker@cmc-nh.org
Medicare QuickStop

Submitted by Gerri Provost, FHFMA
Baker Newman Noyes

• The federal fiscal year (FFY) 2013 proposed inpatient prospective payment system (IPPS) rule was released on April 24, 2012 and published in the Federal Register on May 11, 2012. Comments will be accepted by the Centers for Medicare and Medicaid Services (CMS) until June 25, 2012. Highlights of the FFY2013 IPPS proposed rule, applicable for discharges on/after October 1, 2012 include:

CMS projects an increase of 2.3 percent in payment rates to general acute care hospitals in FFY 2013, a net update after inflation, improvements in productivity, a statutory adjustment factor, and adjustments for hospital documentation and coding changes.

CMS proposes to begin reducing the base operating DRG payment amount by 1.0 percent beginning January 2013 to fund the Hospital Value-Based Purchasing (VBP) program as well as to apply the value-based incentive payments. In future years, all VBP adjustments (reductions and incentive payments) will be applied at the beginning of each FFY.

The proposed rule includes changes relating to determinations of a hospital’s full-time equivalent (FTE) resident cap for GME and IME payments.

CMS is proposing “new or revised” requirements for quality reporting by specific providers...CMS is also proposing new administrative, data completeness and extraordinary circumstance waivers or extension requests requirements, as well as a reconsideration process, for quality reporting by ambulatory surgical centers that are participating in Medicare.”

Beginning in FFY 2013 and continuing annually, CMS will adjust hospital payments based on how hospitals perform or improve their performance on a set of quality measures.

CMS did not propose any major changes to the manner in which the wage index is currently calculated.

CMS proposes a change to include labor and delivery beds in the available bed count for purposes of IME and DSH adjustments. 42 CRF 412.104(b) (4) would be revised to remove “ancillary labor/delivery” services from the list of currently excluded beds. This change could affect DSH and IME payment adjustments, MDH status and OPPS hold harmless payments.

CMS is proposing that a new teaching hospital will have five years, instead of the current three years in which to establish and grow new residency programs before the resident cap would be determined.

CMS is proposing that for any MDH that applies and qualifies for sole community hospital (SCH) classification status at least 30 days prior to the expiration of the MDH program (October 1, 2012) and requests that SCH classification status be effective with the expiration of the MDH program provision, the effective date of the hospital’s classification as an SCH will be the day following the expiration of the MDH program. SCH qualifications have not otherwise changed.

The Affordable Care Act (ACA) eased the eligibility criteria for two years (expiring on October 1, 2012) the discharge bar to 1600 discharges and lowered the distance requirement to 15 miles to qualify for enhanced payments to hospitals with a relatively low number of discharges. For a hospital that qualifies (at the pre-ACA criteria) for low-volume hospital payment adjustments for FFY 2013, it must make its request in writing to its MAC by September 1, 2012.

• Senators Charles Schumer and Charles Grassley introduced the Rural Hospital Access Act of 2012, to amend title XVIII of the SSA to extend for one year both the MDH program and the enhanced payments under the Medicare low-volume hospital program--to October 1, 2013.

• Change Request 7785 (transmittal: 2457), dated April 27, 2012, extends the therapy cap exceptions process through December 31, 2012 and applies the therapy caps to therapy services provided in outpatient hospital settings, effective October 1, 2012 through December 31, 2012. Formerly, therapy services provided in outpatient hospital settings have been exempt from the application of the therapy caps. Although claims processing requirements associated with the cap are only applicable to hospitals on/after October 1, 2012, claims paid for hospital outpatient therapy services since January 1, 2012 will be included in the calculation of the cap. However, unless Congress passes legislation by the end of the year, there will be a therapy cap with no exceptions process for all outpatient therapy settings except hospitals effective January 1, 2013. The therapy cap would not apply to hospitals on/after January 1, 2013 unless Congress passes legislation. Suppliers and providers are required to report the NPI of the physician, or non-physician practitioner responsible for reviewing the therapy plan of care on the beneficiary’s claim form, effective October 1, 2012
FREE Recorded Webinars

Recorded and at your convenience!

If you have missed any of the webinars provided by the Chapter, here is your opportunity to see what you missed! A list of recorded webinars is as follows:

1. **Legislative Update** - presented by Steve Ahnen & M. Beatrice Grause

2. **What is the Cost Report and Who Cares** - presented by Gerri Provost

3. **Revenue Forecasting** - presented by Wendy Fielding

4. **Self-Administered Drugs** - presented by Leslie Haddy

5. **Using Denial Data to Improve Managed Care Contracts** - presented by Robin Fisk

There are links provided for each webinar on the Chapter’s website. This educational time counts towards your CEUs and your registration adds to our education hours for the NH/VT chapter leader’s scorecard.

To access the recorded webinars follow these steps:

1. [www.NHVTHFMA.org](http://www.nhvthfma.org)

2. Education & Events (on left hand side of page)

3. Recorded Webinars (2nd option listed under Education & Events)

4. Recorded Webinars

If you have any questions, contact Diane Blaha at diane.blaha@gmail.com.
Come One, Come All, to the Newsletter Planning Meeting!

The Newsletter Planning Committee will be meeting on Tuesday July 17th at 9am at BerryDunn in Manchester NH. Anyone who is interested in volunteering in any sort of capacity is welcome to attend. We will be discussing items necessary to produce another successful newsletter for the upcoming year. Please email Eric Walker ewalker@cmc-nh.org to reserve your spot for this meeting.

BERRYDUNN IS LOCATED AT:
1000 Elm Street, 15th Floor
Manchester, NH 03101
(603) 669-7337

From I-93 North (Boston/Salem, NH): From I-93 North, merge onto I-293 North via the exit on the left towards the Manchester Boston Regional Airport. Take Exit 5 for Granite Street off I-293 North. At the end of the exit ramp, take a right onto Granite Street. Turn right onto Mechanic Street, and then take your first left onto Plaza Street. The entrance to the Plaza Street Garage will be on your left. Take stairs or elevator to Level 3 and walk East across connector to the Brady Sullivan Plaza Entrance. After you pass the U.S. Post Office (on your left) take a left, then a right. Go past the glass doors towards Security to get to the elevators. BerryDunn is located on the 15th Floor.

From I-93 South: From I-93 South, take the I-293 South/Everett Turnpike towards the Manchester Boston Regional Airport. Take Exit 6 toward Amoskeag Street/Goffstown Road. At the end of the exit ramp, keep right to take the Amoskeag Street ramp toward UNH Manchester/Goffstown Road/Canal Street/Elm Street. Take a right onto Amoskeag Street. At the end of the bridge, veer to the right to turn onto Canal Street. Turn left onto Spring Street, and then take your first right onto Plaza Street. The entrance to the Plaza Street Garage will be on your right. Take stairs or elevator to Level 3 and walk East across connector to the Brady Sullivan Plaza Entrance. After you pass the U.S. Post Office (on your left) take a left, then a right. Go past the glass doors towards Security to get to the elevators. BerryDunn is located on the 15th Floor.

From Maine: Take Route 95 to NH101 West toward Manchester. Continue for approximately 33 miles on NH101 West. Merge onto I-193 North via Exit 7 towards the Manchester Boston Regional Airport. Take Exit 5 for Granite Street off I-293 North. At the end of the exit ramp, take a right onto Granite Street. Turn right onto Mechanic Street, and then take your first left onto Plaza Street. The entrance to the Plaza Street Garage will be on your left. Take stairs or elevator to Level 3 and walk East across connector to the Brady Sullivan Plaza Entrance. After you pass the U.S. Post Office (on your left) take a left, then a right. Go past the glass doors towards Security to get to the elevators. BerryDunn is located on the 15th Floor.

Note: (The Brady Sullivan Plaza parking garage is located at 2 Plaza Drive. Park on any of the five levels):

OBSTACLES TO COLLECTION OF MILLIONS IN MEDICARE OVERPAYMENTS (AUDIT A-04-10-03059)

http://oig.hhs.gov/oas/reports/region4/41003059.asp
The OIG review focused on overpayments that CMS had made and that OIG had recommended for collection. CMS agreed to collect, or “sustained” these overpayments. We selected OIG audit reports on Medicare with recommendations to collect overpayments greater than $1,000 that were issued during fiscal years (FY) 2007 and 2008 and the first 6 months of FY 2009 to CMS, CMS contractors, or Medicare providers.

As of October 8, 2010, CMS had not collected the majority of overpayment amounts identified in OIG audit reports. Of the 154 OIG audit reports with sustained overpayment amounts totaling $416.3 million, CMS reported collecting $84.2 million. Of the $84.2 million, CMS reported collecting the full sustained amounts totaling $83.3 million for 113 reports and partial amounts totaling $896,000 for 8 reports. However, for various reasons, CMS did not collect the remaining $332.1 million. CMS’s collections were limited because of time constraints imposed by the statute of limitations on overpayment collections. In addition, it did not provide its contractors with adequate guidance for collecting overpayments and did not have an effective system for monitoring its contractors’ collection efforts.

Furthermore, we could not verify the $84.2 million that CMS reported collecting, and we identified inaccuracies in the reported amount. These issues arose because CMS did not have adequate systems for (1) documenting overpayment collections identified in OIG audit reports or (2) detecting data entry errors. Therefore, CMS had no assurance that the overpayment collections information that it reported to other parties was accurate.

We recommended that CMS (1) pursue legislation to extend the statute of limitations so that the recovery period exceeds the reopening period for Medicare payments; (2) ensure that its Audit Tracking and Reporting System (ATARS) is updated to accurately reflect the status of audit report recommendations; (3) ensure that CMS staff record collections information consistently in ATARS; (4) collect sustained amounts related to OIG recommendations made after our audit period to the extent allowed under the law; (5) verify that the $84.2 million reported as collected has actually been collected; and (6) provide specific guidance to its contractors concerning the timeframe in which the contractor must take action to collect an overpayment, how to report collections, the type of documentation that the contractor must maintain to substantiate an overpayment collection, and how to report reasons for not collecting overpayments.

In response to our first recommendation, CMS said that it would explore the possibility of pursuing legislative proposals. CMS concurred with our second, third, and sixth recommendations and discussed actions it had taken or planned to take to implement them. CMS partially concurred with our fourth recommendation and did not concur with our fifth recommendation.
Dear Readers,

Thank you so much for your support the past two years in my role as Newsletter Editor for “Mountain Views”. I have truly had a great time working with all on the committee, and will continue to be involved in the newsletter production as a writer. I look forward to working with you for years to come, and continuing to read about all the wonderful things happening in healthcare in our small part of the world. New Hampshire and Vermont may not take up much space on a map, but the two states have tremendous things happening in terms of healthcare reform, revenue cycle efficiencies, leadership, volunteerism, and legislative involvement, just to name a few. The advancement and high energy around these topics is largely in part to your involvement, and not just “topics” we read about in a newsletter, but really something that’s an everyday part of our lives, both professionally and at home. I thank you all for your commitment and dedication to the industry- it’s really something to be proud of!

I’d like to make a special thanks to my “proofers,” who throughout the year find the “devil in the details” for each and every article prior to it being published. Thank you Gerri Provost, Lisa Willis, Jane Kapoian and Sue McHugh! Your attention to detail is much appreciated!

For any of you out there who are interested in joining the newsletter committee and seeing what it’s all about, join the new editor, Eric Walker on July 17th at 9am at Berry Dunn in Manchester, NH. He will be leading the group in planning for the upcoming year-an event not to be missed!

Keep writing, keep reading, and keep the dialogue going.

Thank you for the past two years!

Best,

Kristina Griffin
Welcome Summer 2012 New Chapter Members

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<tr>
<th>Name</th>
<th>Title</th>
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<tr>
<td>Trisha Gagnon</td>
<td>Revenue Manager</td>
<td>Wentworth-Douglass Hospital</td>
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<td>Sarah Santor</td>
<td>Staff Accountant</td>
<td>Vermont Managed Care</td>
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<td>Whitney Hoyle</td>
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<td>EOS CCA</td>
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<td>Randy Cook</td>
<td>Director of Contracting and Revenue Strategy</td>
<td>Fletcher Allen Health Care</td>
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<td>Marc Steven Gilman</td>
<td>Managing Director</td>
<td>Expense Reduction Analysts</td>
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<td>Jennifer Malynowski</td>
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<td>Benuck &amp; Rainey, Inc.</td>
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<td>Lea Bruch</td>
<td>Director HIM/Privacy Officer</td>
<td>Alice Peck Day Memorial Hospital</td>
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<td>Rita Conley</td>
<td>Coding Advisor</td>
<td>Alice Peck Day Memorial Hospital</td>
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<td>Maura Eaves</td>
<td>Insurance Receivables Specialist</td>
<td>Alice Peck Day Memorial Hospital</td>
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<td>Wanda Stevens</td>
<td>Revenue Cycle Assistant</td>
<td>Alice Peck Day Memorial Hospital</td>
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<tr>
<td>Susan Ackerson</td>
<td>Supervisor- Referral Services</td>
<td>Dartmouth Hitchcock Clinic</td>
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<tr>
<td>Margaret Stortstrom</td>
<td>Provider Enrollment Specialist</td>
<td>Dartmouth Hitchcock Clinic</td>
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<td>Kristen Peck</td>
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<td>Huron Consulting Group</td>
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<td>Lindsay Hamel</td>
<td>Finance Manager</td>
<td>Medicus Healthcare Solutions</td>
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<td>Carolyn Tice</td>
<td>Audit Coordinator HIM/ROI</td>
<td>Fletcher Allen Health Care</td>
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<td>Anne Murrock</td>
<td>Business Analyst</td>
<td>Cheshire Medical Center</td>
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<td>George Langdon</td>
<td>Vice President &amp; General Manager</td>
<td>GE Healthcare</td>
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<td>Kimberly Hess</td>
<td>Contract Analyst</td>
<td>Fletcher Allen Health Care</td>
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<td>Elizabeth Bennett</td>
<td>Revenue Cycle Jr Analyst</td>
<td>Dartmouth Hitchcock Medical Center</td>
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<td>Ronald Vincent</td>
<td>Financial/Operators Analyst</td>
<td>New London Hospital</td>
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Welcome Summer!!!

BerryDunn's team of seasoned professionals puts its audit, tax, and consulting know-how to work for you in a way that fits your operational style. Our hospital and health care system professionals stay on the leading edge of health care financial issues and strategies, combining our industry knowledge with an understanding of your organization's strategic goals to help you make better-informed decisions. We help you capitalize on opportunities that drive value—all with more control!

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The New Hampshire/Vermont Chapter of the Healthcare Financial Management Association (HFMA) is a professional membership organization for individuals in financial management of healthcare institutions and related patient organizations.

If you can read this...

Then you should consider joining the newsletter committee!

Do you enjoy reading Mountain Views?

Are you looking to network and get more involved in the NH/VT HFMA chapter?

Consider joining the newsletter committee!
Commitment is flexible around how involved you want to become!
We are always looking for new writers, and for people to reach out and contact prospective contributors.

Contact Kristina Griffin at kgriffin0509@gmail.com or Eric Walker at ewalker@cmc-nh.org if you’re interested in learning more!