I. A REVIEW OF THE 2013 OFFICE OF INSPECTOR GENERAL WORK PLAN

It’s October again and, as we all expected, the 2013 OIG audit list relative to possible healthcare fraud and abuse has been published. The document is filled with a plethora of new topics and proposed audit activities as well as continuation of audit activities on subjects from years past. The continuation of reviews indicates that the OIG has not satisfied their objectives for the review and does not appear to be winding down or losing interest in its ongoing activities.

This fiscal year’s list is quite similar to prior years but holds a few surprise categories with the OIG not providing much clarification or specifics related to the subject to be reviewed. So that healthcare providers may be better prepared in scheduling their own internal monitoring and reviews, we have prepared an overview of some of the more significant 2013 OIG audit topics highlighting the issue and providing insight into the subject matter.

**Hospital Concerns and Guidance Medicare**

**Present on Admission (POA)**

The OIG plans to review the accuracy of hospital POA reporting submitted on the acute inpatient hospital claims.

POA indicators are required to be reported for each diagnosis (ICD-9) code. Medicare reimbursement is reduced when certain hospital acquired conditions are identified.

Hospitals should ensure current DRG Validation processes, which are traditionally part of Hospital Compliance internal reviews, including validating the present on admission indicator reported on the claim based on documentation in the medical record.

**Inpatient Outlier Payments**

Hospitals receiving inpatient outliers will be examined nationally, identifying the characteristics of hospitals with high or increasing percentages of cost outlier. Whistleblower lawsuits have increased over the last few years and have resulted in large monetary settlements. Some of the hospitals involved in these lawsuits have been found to have inflated claim charges to qualify for outlier consideration.

Hospitals should adopt policy relating to price setting within the hospital chargemaster. Price setting should be reasonable and have some basis in cost of service.

(Cont’d on page 3)
Words From Your President

Hello everyone. As the chillier air sets in, I can’t help but feel as though it was just yesterday since the previous newsletter deadline. It seems the theme with most everyone—that everything is on fast forward much more so than usual, as we determine where reform will take us and work through our busier schedules. In the short time of two months, there can be so much to report on what we have all been up to, and this is certainly true for the NH-VT Chapter and the services it provides.

Educational Opportunities

Through mid-October we have had 4 webinars, 2 of those through our new Speakers Bureau which has brought us the topics of Utilizing the 276/277 Transaction and CMS Exclusion Screening. The Speakers Bureau webinars are a quarterly offering presented to you by sponsors selected through an application process. This has been a great way for the Chapter to bring great speakers and timely topics quickly and easily to your office. If you were unable to attend any of our webinars, such as the recent legislative update by NHHA and VAHHS, please check out our website for recordings. You can access our webinars through the Education portion of our website under Recorded Webinars.

There have been 2 live programs. The first was Clearing the Mystery of Form 990 Schedule H & Lessons Learned from IRS Audits of Tax Exempt Bonds, explaining the proposed Community Benefit changes and providing practical tools for maintaining your tax-exempt bond compliance. This was held at the Courtyard Marriott in Lebanon.

This year we have taken the initiative to revamp the annual Claims Workshop into 2 separate programs, the Fall and Spring Institutes, to better serve our members geographically and provide greater educational offerings at continued low pricing. The Fall Institute was held at the Grappone in Concord, New Hampshire. With over 170 in attendance, the program was a huge success in content and networking opportunities.

Through the Patient Financial Services (PFS) groups within our state hospital associations, we are also offering an ICD-10 series that serves as education and a forum for PFS staff to exchange ideas. The first session was held September 21st, immediately following NHHA’s PFS regular meeting. The session was presented by John Behn of Stroudwater and was available both live and via webinar to connect with our Vermont PFS group. The series will continue throughout the ICD-10 implementation process and bring forward information and discussion of current issues.

Please check out our Education Calendar in this newsletter for the great programs we have lined up in the coming months. Mark your calendars as well for the Chapter’s Annual Meeting to be held March 14-15th.

Professional Opportunities

Through the efforts of our Certification Committee, we have had a tremendous continuation of members studying for their HFMA certification and passing the exam. By offering certification study classes via webinars at a convenient time or by recording over several weeks, members have received a great service in a manner that has helped them be successful in obtaining their designation. The Chapter also provides a financial incentive to those that pass the exam.

HFMA’s certification program seeks to bring stature to the profession of healthcare financial management as well as offer qualified members an opportunity to upgrade their professional status. The long valued CHFP® (Certified Healthcare Financial Professional) and FHFMA (Fellow of HFMA) certifications demonstrate your qualifications to senior management, coworkers, and the industry—highlighting your commitment to the profession and to maintaining up-to-date skills and knowledge. New in 2011 and available to nonmembers, the Certified Revenue Cycle Representative (CRCR) program helps set standards of performance for revenue cycle staff. By becoming certified in the CRCR program, you or your team has the designation that proves a high level of
Review of Inpatient and Outpatient Payments (PPS)

The OIG proposes to use their sophisticated data mining tools as well as computer system matching programs to select claims failing to conform to specific CMS billing requirements. They will focus on those failures to comply with billing instructions that result in hospital overpayments.

This type of review is broad and, without more specific criteria, hospitals will be open to an aggregate of potential review issues. Hospitals are advised to monitor and review billing requirements as published in the Internet Only Manuals.

Acute Hospital /Post Acute Transfers

The government will continue to review payments made for post acute care transfer DRGs to assure appropriate coding of patient status at discharge. Reviews will center on reviewing the status codes to assure the correct payment calculation to ensure that no overpayments exist based on discharge status.

Hospitals should review their transfer coding policies to ensure compliance with associated rules.

Outpatient Hospital Dental Claims

Medicare considers dental services to be excluded from Medicare coverage. The OIG plans to investigate hospital outpatient claims adjudicated to payment for dental related services and possible provider overpayments.

Hospitals should ensure procedures are in place in the billing office to prevent claim submissions to Medicare for non-covered statutory excluded services. This process should include screening for non-covered services but also related and incidental services associated with these non-covered services.

Critical Access Hospitals

Eligibility Requirements Critical access hospitals (CAHs) are not exempt from OIG scrutiny. A new objective this year will be to review CAHs in order to profile them as to their size, the number of patients, services provided and their distance from other hospitals. The OIG will also be reviewing compliance with the CAH conditions of participation.

From what little guidance has been provided, it appears the OIG is not only ensuring that CAHs continue to meet the fairly strict eligibility requirements, but is also gathering somewhat general data on the types of services provided (to be used down the road?). CAHs should ensure they meet all distance, bed size and average length of stay requirements as well as other CoP.

Swing Beds

The OIG is also concerned with the payment methodology for CAH swing beds. It is initiating a review of this methodology to ensure payment to CAHs for this level of service is reasonable and appropriate.

Long-Term Care Hospitals

The OIG wants to determine the extent to which Medicare made improper payments for interrupted stays in long-term care hospitals (LTCH) in 2011. It also plans to identify readmission patterns and determine the extent to which LTCHs readmit patients directly following the interrupted stay periods. An interrupted stay occurs when a patient is discharged from an LTCH for treatment and services that are not available at the LTCH and is readmitted after a specific number of days.

In the past, the OIG has identified vulnerabilities in CMS’s ability to detect readmissions and appropriately pay for interrupted stays.

The Work Plan adds topics of interest and continues to support the OIG’s concern and continuation of reviews associated with State Medicaid program involvement with drug rebate programs, State coverage under the Home Community and Personal Care services, State provider and supplier reimbursement policies, provider termination and the Medicaid integrity program audits.

Physician Concerns and Guidance

Place of Service Errors

The OIG continues to review place of service assignment for services rendered in ambulatory surgical centers and outpatient departments of hospitals. Since physician, including non-physician practitioner (NPP), reimbursement is paid at a higher rate when services are rendered in the non-
2013 OIG Workplan Update

facility setting such as the office, the OIG is concerned that physician practices are not assigning the correct place of service when patients receive care in outpatient departments of a hospital or other non-office settings.

This can be a major issue if your practice has become a department of a hospital known in Medicare parlance as a Provider Based Entity (PBE). As a PBE, the practice becomes integrated into the facility and, as such, holds itself out as a department of the hospital. Medicare patients are considered hospital outpatients when they receive services at a PBE and, as such, their visits must be billed with an outpatient place of service code.

OIG Issue: Incident-To Services

This is not a new issue for the OIG but continues to be a concern. The OIG wants to find out if services not personally performed by a physician but billed under the physician’s name (incident-to) are being reported appropriately. It states its concern as: there is no way to confirm from claims data which services billed are performed incident-to; a 2009 OIG review found 21 percent of services reviewed were performed by non-qualified personnel.

Medicare defines incident-to as the services or supplies that are furnished as an integral although incidental part of the physician’s professional services.

Incident-to requirements include: the service must be an integral part of the physician’s plan of care (services may not be for a new patient or a new problem); on-going physician involvement; direct personal supervision by the physician. In addition, both the physician and NPP/auxiliary personnel must have a direct employment relationship or is a leased employee or must be employed by the same group AND the physician must be present in the office suite and immediately available if needed. Service must be provided in the office or in the home, other non-hospital or SNF setting. If these requirements are met, the service may be billed under the supervising physician’s name. See the Medicare Benefit Policy Manual (pub 100-2), Chapter 15, Covered Medical and Other Health Services, Subsection 60, Service and Supplies: [http://www.cms.hhs.gov/manuals/102_policy/bp102c15.pdf](http://www.cms.hhs.gov/manuals/102_policy/bp102c15.pdf) for more information.

Let’s not forget; the person performing the service must be qualified and the services must be medically necessary. That means different things depending upon what services are performed. For example, it is within the scope of a registered nurse’s license to perform the insertion of a non-indwelling bladder catheter but not in a medical assistant’s scope. So, in this example, if the physician ordered the insertion of the catheter for a sterile urine specimen, the service could be considered a billable incident-to procedure if performed by a RN (if all the other incident-to requirements are met) but non-billable if performed by a medical assistant.

To support billing services incident-to documentation must include: the name of the physician whose care plan is being followed, the reason for the visit, a description of the services being rendered and the name of the physician/NPP who is supervising at the time the service is being provided. NHIC, our J-14 MAC, also requires that the supervising provider co-sign the note.

Incident to is not allowed in a hospital setting just a free standing physician office. Hospitals should continue to educate your staff on the specific requirements surrounding incident-to services and billing. Make sure documentation supports the incident-to service. You may have to revise your documentation templates and workflows to make sure you are being compliant.

Evaluation and Management Services (Multiple Issues), Trends in Coding of Claims

The OIG continues to review E/M services for aberrant billing patterns. The goal is to confirm that the appropriate level and type of E/M service is being billed.

We have been living with this type of scrutiny for decades, but with EHRs becoming more prevalent, the level of review is becoming more intense. The key is to provide ongoing education and training to your practitioners and continue your chart review activities to ensure compliance.

Services Provided During Global Surgery Periods

This is a continued review of practices related to the number of follow-up E/M services provided by physicians as part of the global surgery period to determine whether the practices have changed since the global surgery fee concept was introduced.

Use of Modifiers During the Global Surgery Period

This is a natural addition related to the review of global surgery periods. The only way to pull a service out of the global window for separate payment is to append a modifier (i.e. 24, 57). The OIG wants to determine if services provided during a global surgical period and billed with any of the aforementioned modifiers are being reimbursed appropriately. The concern is that the application of one of these modifiers is correctly identifying the service billed as being outside and/or unrelated to the global procedure.

Potential Inappropriate Payments

As electronic health records (EHRs) proliferate, the OIG says it will continue to target over documented “cloned” E/M services as an area for review.

Per Medicare IOM Manuals 100-04 Chapter 12 Section 30.6.1.A: “Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when
a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.”

The take home on this one is to make sure you review your EHR to identify how/if copying of previous visits are allowed. If information is copied forward, is it identified as historical data or treated as “brand new” for that date of service? Critically look at your templates. Are they overly prefilled? Does the practitioner’s history of present illness contradict the review of systems? Does the history contradict the exam? Most importantly, does the acuity of the medical decision making support the level of service billed? In simple terms, was it medically necessary to document a comprehensive history and exam for a patient with a stubbed toe?

Expect this issue to continue to be an area of review as EHR’s implementation continues. Due diligence is going to be required to assure that acuity supports the code billed.

Other Physician Issues in Brief

Ophthamological reviews: Claims will be reviewed to identify over-utilization and other coding errors, particularly with the use of E/M codes as opposed to “eye” codes. 2011 data will be utilized for this review.

Compliance with Assignment Rules: The OIG will continue to review whether providers are complying with assignment rules and determine to what extent beneficiaries are inappropriately billed in excess of amounts allowed by Medicare.

Part B Imaging Services: Part B imaging services will continue to be reviewed to determine whether the services reflect expenses incurred and whether the utilization rates reflect industry practices.

Diagnostic Radiology Services: Medical necessity will continue to be reviewed for high dollar imaging as well as reviews of duplicate services being ordered by different specialists.

Sleep Testing: the OIG is concerned that there has been an increased in the number of sleep studies billed from 2001-2009. They are reviewing to confirm the medical necessity of sleep studies billed.

Summary of the OIG Work Plan

In its spring 2012 report to Congress (covering the 6 month period ended March 31, 2012), the OIG reported expected recoveries of approximately $1.2 billion. It further accomplished 1,264 individual/entity exclusions from participation, 384 criminal convictions and 164 civil actions. It is increasing its use of its extensive data base to data mine for more efficiency and effectiveness in pinpointing its oversight efforts.

It is clear, based on the successes described in its semi-annual report to Congress and on its website, that the OIG will remain extremely active in its audit and review activities of all provider types.

3 Day Payment Window: CMS has clarified in its final inpatient PPS rule that the 3 day payment window applies to both preadmission diagnostic and non diagnostic services furnished to patients by physicians that are wholly owned or wholly operated by the admitting hospital. This can have significant implications for those physicians and physician practices that are not provider-based entities but are wholly owned or operated by a hospital.

PEPPER reports: A hospital’s PEPPER report (Program for evaluating payment patterns report) can be a very effective tool for assisting in compliance with case management of inpatient care. If aberrations are identified on this report, hospitals can use this information to help prioritize internal compliance efforts.

III. CONCLUSION

The Department of Health and Human Services, through its agencies, is remaining ever vigilant in its oversight of Medicare and Medicaid payments to healthcare providers across the continuum of care. The future appears no different and, in fact, appears to include even more oversight than currently exists. Providers should carefully review and analyze each of the many work plans and rules that have been published in the past few months in order to determine applicability to each individual circumstance. The result should be to proactively assess the impact to the individual organization as proper planning and oversight is instrumental to a successful compliance outcome.
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Member Services in Fast Motion

(From your President from page 2)

revenue cycle knowledge and expertise has been reached.

These are only a few of the benefits provided through your membership. We hope you will take advantage of the several others available to you both locally and nationally. As National HFMA leadership reminds us, it is in these fast times that members look even more to HFMA for knowledge, information and networking. Be involved as a member. If you have suggestions and comments on how better to serve you and to meet your needs, please feel free to contact me or any board member or officer.

Thank you for your continued support of the NH-VT Chapter.

Sincerely,
Connie Ouellette
Chapter President

NHHA Eyeing Early Legislative Proposals at State House

By Leslie Melby, New Hampshire Hospital Association

The NHHA is closely watching as legislators file their proposed bills for the 2013 legislative session. The first filing period closed September 26 with a total of 259 proposals submitted. Incumbent members and newly elected legislators will resume filing "LSRs" (Legislative Service Requests) after Election Day. LSRs consist of titles only, so no details on the actual proposals are publicly available. Legislative staffers research the proposal and draft the resulting bills that are usually available online by late December.

Some bill titles are more explicit than others. However, there's no doubt as to what Speaker Bill O'Brien has in mind for his proposed LSR entitled, "Stating that New Hampshire will not accept expanded Medicaid." If O'Brien's bill passes next year, New Hampshire will be unable to extend Medicaid coverage to approximately 50,000 NH citizens earning up to 138 percent of the federal poverty level, and that would have been funded with 100 percent federal dollars until 2017.

Two hepatitis-C related bills proposed by Rep. Lee Quandt are less specific - "relative to mandatory drug testing for certain health care workers" and "relative to registration for certain health care workers." Will Rep. Quandt's drug testing bill specify what types of drugs for which employees will be tested? Frequency of testing? Which categories of employees? Consequences of positive testing? Will the healthcare worker registration bill create a new catch-all Board for health care workers not currently regulated by the State? These are questions without answers at the moment.

Rep. Laurie Harding is proposing a bill to address community mental health services, while Rep. Jennifer Coffey is proposing to increase the number of mental health beds statewide, as well as to study issues relating to the custody of mentally ill persons held in correctional facilities.

There's much more to come as the filing of legislative proposals resumes November 13th. And last but not least, the state budget bills - HB 1 and HB 2 - will be introduced following the Governor's budget address this coming February.

Thank you for your continued support of the NH-VT Chapter.

Sincerely,
Connie Ouellette
Chapter President

Winter is upon us!!
Get Involved Volunteers!

The members who get the most out of HFMA are the ones who get involved. Volunteers are the heart of our chapter. Opportunities range from quick jobs to on-going positions, from one time gigs to year-long commitments; all are important, and one of them may be just right for you!

When you volunteer, you take away something new; a skill, a contact, a feeling of membership. And when you volunteer, the chapter gets the help needed with an event, newsletter, or web-page. You make a difference!

Thank You!

We would like to celebrate some members who have recently volunteered for the first time, or expanded their services to new areas:

- Mike Long, Longview Consulting
- Nick Jaidar, Fletcher Allen Healthcare
- Tracy Jordan, New London Hospital
- Carol Barrett, Elliot Hospital

For a list of current opportunities, go to our website at [http://www.nhvthfma.org](http://www.nhvthfma.org) or email Judi Deavers at judith.a.deavers@hitchcock.org

CHFP Certification

Carol J. Barrett CHFP
Elliot Hospital
Director, Nursing Finance

As Healthcare Financial Professionals we receive countless e-mails. Many just get the “delete” button, and that was almost the fate of an e-mail I received from HFMA which asked the questions “Get Certified? Are you Crazy?” I was about to delete the e-mail, when I hesitated, maybe I am a little crazy!!

NH/VT HFMA, in conjunction with the HFMA chapters in Arizona, Connecticut, and Wisconsin, had put together a program that offered educational support and a financial incentive to pass the CHFP exam. I was a bit unsure if I had enough detail knowledge in all of the areas to pass the exam. I certainly had confidence in my Budgeting and Financial Accounting knowledge, but it had been a while since I had been involved in the area of Internal Control and I had minimal Revenue Cycle background.

The information supplied by HFMA suggested that I take the HFMA Sample Certification Exam that was offered free on the HFMA website. Since it had been quite a while since I had taken any type of exam, this gave me an idea of the structure of on-line test taking. The last formal exam I had taken was with “number 2” pencils!!!

I registered to be part of the NH cohort of 16 financial professionals who joined 63 others from across the country. I took the on-line CHFP Preparation Course, taking detailed notes as I went through each module. I found the material in this Course to be very helpful. I also participated in a four part series of live webinars provided by the participating HFMA chapters. In addition Gerry Provost provided me with questions that had been published in the HFMA newsletter. I studied these materials a few evenings a week and spent some time studying on the weekends. I took my notes on car trips and used that time to study as well.

I registered to take the exam on a Saturday morning in late August, 2012 at a testing center in Nashua. The actual exam structure mimicked the HFMA Sample Certification Exam. As I pushed the submit exam button, I held my breath and waited for the results… congratulations you passed!!!

At the beginning of the summer I had not planned to become a Certified Healthcare Financial Professional, but the e-mail I received changed the course of my summer. Instead of enjoying a few “romance” novels, I learned more about my profession and gained certification. I would recommend this certification program to anyone who wants to advance as a Healthcare Financial Professional. My next “Am I Crazy,” FHFMA Certification!!
Certified Revenue Cycle Representative (CRCR) Program

The new Certified Revenue Cycle Representative (CRCR) Program helps set standards of performance for revenue cycle staff. By becoming certified in the CRCR Program, you earn the designation that indicates that a high level of revenue cycle knowledge and expertise has been reached.

CRCR benefits for individuals:

- Achieves a recognized professional certification and designation by the leading healthcare finance professional association
- Provides verification of professional competencies and currency
- Enhances a deep understanding of revenue cycle operations
- Demonstrates a commitment of professional growth

A comprehensive online self-study course, and an online exam with 150 questions, our NH/VT HFMA Chapter celebrates our first certified CRCR member. Congratulations go out to our first CRCR candidate:

Todd J. Thompson, CRCR Director of Patient Access at Alice Peck Day Memorial Hospital

If you have questions about the CHFP or CRCR certifications, please contact our Certification Committee Co-chairs: Diane Blaha at diane.blaha@gmail.com or Peter Smith at peter.smith@wdhospital.com.

Meaningful Use Stage 2

In Stage 1 Meaningful Use regulations, CMS established an original timeline that would have required Medicare providers who first demonstrated Meaningful Use in 2011 to meet the Stage 2 criteria in 2013. The Stage 2 Final Rules issued in August 2012 gives providers more time to meet Stage 2 criteria. A provider that attested to Stage 1 of Meaningful Use in 2011 would attest to Stage 2 in 2014, instead of in 2013. Therefore, providers are not required to meet Stage 2 Meaningful Use before 2014.

The Rules are very complicated and are difficult to summarize into a newsletter article. At http://www.vitl.net/stage 2, VITL has developed a link that reduces the Rule into:

Meaningful Use Stage 2 Final Rules
CMS Fact Sheet on Stage 2
Stage 1 Changes Tipsheet
Stage 1 vs. Stage 2
Stage 2 Overview Tipsheet
“I turn to HFMA to keep up with the rapid change in the profession, enhance my career and strengthen our chapter. HFMA delivers the essential information that healthcare financial management professionals require to stay on top of their game and ahead of the curve.”

Mark A. Hartman, FHFMA, CPA, SVP Finance & Treasurer, Arkansas Heart Hospital

“be informed.
be engaged.
belong.”

HFMA is where healthcare finance professionals need to be...

Pass it on.

Member-Get-A-Member Program 2012-2013

Visit hfma.org/mgam for details on the program, and a listing of prizes.

Earn valuable rewards when you share your commitment to HFMA.

Recruit 1-2 members and choose between:
• HFMA apparel item (approximate retail value $25).
• $25 Visa debit card accepted worldwide.

Recruit 3-4 members and receive:
• $100 Visa debit card accepted worldwide.
• Entry into a drawing (of those recruiting 3-4 members) for $1,000.

Recruit 5 or more members and receive:
• $150 Visa debit card accepted worldwide.
• Entry into a drawing (of those recruiting 5 or more members) for $2,500.

For every member you recruit, your name is entered in:
• Drawing for a brand new iPad (three drawings in all)
• Drawing for the Grand Prize worth $5,000 – $3,000 for you and a $2,000 donation in your name to the charity of your choice.

The more members you sponsor, the greater your chances to win!
Our Chapter’s LINK Committee in Action

HFMA recently issued a six-page Comment Letter directed to the Internal Revenue Service regarding the Department of the Treasury’s and Internal Revenue Service’s proposed regulations relating to the 501(r) provisions found in the Affordable Care Act.

On September 10, chapter LINK committee chairs were asked to provide local input to HFMA on five identified topic areas as HFMA drafted a comment letter to the IRS regarding its proposed rule related to hospital collections activity for not-for-profit hospitals. The turnaround time was quick seven days. On September 24 HFMA issued a comment letter directed to the Internal Revenue Service regarding the Department of the Treasury’s and Internal Revenue Service’s proposed regulations relating to the 501(r) provisions found in the Affordable Care Act.

In the letter, HFMA addresses the Treasury’s efforts to more clearly define the additional procedures that 501(c)(3) hospitals must follow for the financial assistance, billing, and collection requirements outlined in the ACA. HFMA notes that it believes clarification and change in the proposed rule is needed to address the following issues:

- Inconsistent standards and unintended consequences
- HFMA provides recommendations that address each of the aforementioned issues. The goal of the letter is to assist the Internal Revenue Service and Department of the Treasury in creating a simplified, standardized, and non-duplicative program.

Background - Chapter LINK Committee

HFMA’s LINK (Local Information Netwok) committee provide local perspective on impact of Accountable Care Act (ACA), ramifications and response strategies for providers, payers, employers and communities, and input and comment on HFMA's positions. The outcome of the committee’s work reinforces the seamless system of service on issues of importance to HFMA members, informs HFMA’s various Advisory Committees (ACs) of ramifications at the local level, provides an opportunity to engage additional healthcare executives at the local level, and supports comment letter development.

How does the process work?

- CMS releases regulations.
- Staff prepares summary of issues, timing, etc. and develops key questions to inform on key state/local issues.
- Summary, questions and other information is sent to LINK committee chair. The LINK committee chair gathers responses from committee members and summarizes the aggregate view with focus on size, geography, and communities served and returns to staff within the specified period of time.
- HFMA develops a Comment Letter using LINK committee feedback along with other input. Once the Comment Letter is cleared with the Executive Committee of HFMA Board of Directors, it is then submitted to CMS under the signature of HFMA’s President and CEO, Joseph J. Fifer.

Interested in Becoming Involved?

The LINK committee chair is the lead volunteer at local level to coordinate input and response to HRAC. The LINK committee is usually made up of CFOs, CEOs, CMOs, revenue cycle executives, and others providing input to LINK committee chair. The call for comments is approximately three to four times a year — each with a short response of seven to ten days. Our chapter’s LINK committee chair is Robin Fisk. Committee members include Dick Ford and Gerri Provost. If you are interested in learning more about the committee, contact Robin Fisk, LINK chair at rf@fisklawoffice.com.
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Winter is upon us!!
The Value of Certification

Many healthcare organizations in today’s challenging economy recognize their workforce as their most valuable asset. As such, these organizations tend to hold workforce development as a primary business strategy.

Investment in developing the talents, knowledge and skill sets of staffs are critical to the organization’s success. HFMA’s Healthcare Financial Pulse research identified this dynamic and noted that successful organizations today commit to the “bread and butter” of financial management, i.e. technically strong and comprehensive financial management.

Likewise, many individual financial managers today recognize the importance of assuming personal responsibility for their careers’ success. More than ever before, individuals understand the importance of acquiring and maintaining comprehensive skill sets to ensure their ability to provide the financial management demanded today. These individuals frequently seek out relevant professional development opportunities.

The larger business environment resulting from these forces is a heightened interest in workforce development initiatives including certifications and credentialing. Credentialing programs have exploded across the past couple of decades and include:

- professional associations offering certifications
- community colleges offering curriculum-based certificates
- corporate sponsored in-house credentials for employees
- technology companies providing proprietary credentials to customers

HFMA certification provides a fundamental business service to our industry, namely HFMA certification offers:

- Assessment of job-related competency
- The opportunity for an individual to demonstrate skills and knowledge
- Independent verification of the skills and knowledge
- Confirmation that an individual is current in the practice field

The value of HFMA certification can be seen in several reported “value-adds”:

- Increased departmental cooperation
- Heightened self-confidence among participants
- Increased performance against selected metrics
- Verification of staff knowledge and skills
- Assistance in structuring career paths

HFMA is committed to being the indispensable resource that defines, realizes and advances healthcare financial management practice. As such, HFMA provides professional certifications to achieve this purpose in today’s business environment. This makes HFMA Certification a smart workforce investment strategy.

For more information on HFMA Certification, visit [http://www.hfma.org/certification](http://www.hfma.org/certification).

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Because of the generosity of the organizations listed below, we are able to offer quality services, such as this newsletter, to our members. To these organizations, we say thank you.

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We’d like to welcome Randy Cook to our Chapter. Randy is the Director of Contracting & Revenue Strategy for Fletcher Allen Health Care. Mr. Cook started at Fletcher this past April and prior to joining Fletcher Allen, he was the Vice President for Regional Contracts for Assurant Health.

When asked what he enjoys most about his work, Randy stated: “Having worked for insurance companies for the past 25 years, I am enjoying the opportunity to sit on the opposite side of the table and negotiate from the provider community’s perspective. I particularly enjoy working for Fletcher Allen Health Care because they are involved with so many innovative initiatives, such as the new OneCare Vermont ACO and the Vermont Health CO-OP.” Randy is responsible for determining operational or financial contracting targets and working with the payers to make those targets a reality.

Randy stated that some of the different healthcare issues that he faces are due to the rapid changing healthcare environment. He feels that the establishment of health benefit exchanges and moving toward an Accountable Care Organization all affect contracting. Additionally, Randy feels that one of the largest challenges is accurately understanding the financial risk with these changes, in particular the risk for revenue loss with physicians and hospitals related to the implementation of ICD-10 in 2014.

Randy joined HFMA to learn from his peers and to take advantage of the educational opportunities offered. Additionally he is hoping HFMA will help keep issues on his radar so he can be prepared before those issues become problems.

Randy lived in Boston for the past 25 years and has a 17 year old daughter who is a senior there. Randy was recently married this past October 7th. Please join us in welcoming Randy to our chapter!
New Board Member Profile – Robert Gilbert

Submitted by Amy Vaughan, Fletcher Allen Healthcare

The NH/VT HFMA is pleased to welcome Rob Gilbert to his first term on the Chapter’s Board of Directors. Rob first joined HFMA as a student member in 2006 when he was at the University of New Hampshire working towards his Bachelor’s Degree in Health Management and Policy. He started his health care career at LRGHealthcare after graduation, serving as the Reimbursement Manager specializing in Charge Master and Charge Capture. In 2009, Rob was hired at Wentworth-Douglass Hospital, where he currently serves as Revenue Manager with oversight over a wide variety of Hospital and Professional areas, including Revenue Analytics, Medicare and Medicaid A/R, Denials, Cash Processing, Charge Master, Charge Capture, Revenue Cycle Education, RAC Coordination, and DNFB and Medical Necessity Improvement.

Rob has already experienced first-hand the positive impact that HFMA involvement can have on one’s career. It was through his early involvement in the chapter’s activities, particularly his active participation on the Newsletter Committee, which allowed him to make a connection with Wentworth-Douglass Hospital and led to the position he holds today. Rob values networking opportunities available through HFMA, commenting “I enjoy meeting and networking with new people. Healthcare is only going to get more complicated, so making connections and having the opportunity to leverage colleagues’ talents and knowledge will be critical in increasing Health Care efficiency in the future.”

Rob is currently pursuing an MBA at Southern New Hampshire University, and expects to complete his degree in March 2013. When he is not working or studying, Rob’s hobbies include British sports cars (MG-B), cooking, skiing, camping, and taking day trips with his wife, Alexis, and their son, Braden.

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 Certification Webinars

Pre-Recorded for your convenience!

If you have missed the past two On-Line Certification Study Groups, here is your opportunity to participate! Four chapters, WI, McMahon Illinois, 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 balanced 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 or Peter Smith our Co-Certification Chairs, at diane.blaha@gmail.com or peter.smith@wdhospital.com
National and Regional HFMA Update

By Connie J. Ouellette

HFMA Board of Directors Strategic Planning Session

The HFMA Board of Directors met in August to focus on long-term strategic planning for the Association. The retreat began with an overview to develop a shared understanding of HFMA's position, trends, and response for membership, products, services, and engagement.

The discussion shifted to identifying the strategic parameters for HFMA as we plan our future direction. The board was asked to define, at a high level, the scope and boundaries within which the organization will accomplish its mission. The output centered around becoming "The" leadership organization for strategy, finance and measurement and being known as the credible convener and the go-to source for information, education, networking, and other resources to solve organizational problems.

Healthcare Leadership Council (HLC)

The HLC was created in 2009 to complement the guidance provided by the HFMA Board of Directors and to serve in an important advisory role to HFMA’s leadership for key issues that impact HFMA members and healthcare finance. The current HLC members are:

- Suzanne Delbanco, Executive Director, Catalyst for Payment Reform
- John Glaser, Ph.D., CEO, Health Services, Siemens Healthcare
- Karen Ignagni, President & CEO, America’s Health Insurance Plans (AHIP)
- Paul Keckley, Ph.D., Executive Director, Deloitte Center for Health Solutions
- Judith Persichilli, R.N., B.S.N., M.A., President & CEO, Catholic Healthcare East
- Lee B. Sacks, M.D., Executive Vice President and CMO, Advocate Health Care; CEO, Advocate Physician Partners
- Simon Stevens, Executive Vice President, UnitedHealth Group

Discussion with HFMA’s Healthcare Leadership Council and the HFMA Board in July centered on macro challenges affecting the industry including cost containment and clinical transformation to reduce variation; Accountable Care Organizations (ACOs), bundled payment, and value-based purchasing; and engaging employers and patients to drive change.

Information gathered from the HLC meeting fed into the August HFMA Board of Directors discussions about the implications of reform and market shifts for HFMA.

Regional Update

Every Fall the Regional executives and Chapter presidents and president-elects of our region (NH-VT, CT, MA-RI, and ME) have a multi-day meeting called Fall Presidents Meeting (FPM) to discuss regional issues and share in best practices. We were very fortunate this year to have several important guests join us: Joe Fifer (HFMA’s new President & CEO); Kari Cornicelli (National Board member and CFO from San Diego Chapter), and Eileen Crowe (National staff member). Aside from some evening time to enjoy the Cape, there was a lot of good discussion by and about each chapter. From a NH-VT perspective, Sandra Pinette and I shared our initiatives in education delivery, our certification success story, and some of our strategic planning initiatives such as increasing volunteerism. Merger and acquisition and affiliation activity was a specific agenda item this year, given we are all seeing activity in varying degrees, and what impacts we’ve seen. Our guests provided us with great access to knowledge of HFMA nationally and the industry. One very important message we heard was the power of knowledge and education during tougher economic times and that HFMA program attendance increases as a result.
IRS Releases Proposed Regulations on New Internal Revenue Code Section 501 (r) Applicable to Hospital Organizations

by Scott J. Mariani, JD and Karen L. Henderson, CPA

On June 22, 2012, the Internal Revenue Service ("IRS") released proposed regulations (26 CFR Part 1, REG-130266-11) addressing three (3) of the four (4) new Internal Revenue Code ("IRC") Section 501(r) requirements applicable to tax-exempt hospital organizations. The Patient Protection and Affordable Care Act ("Affordable Care Act"), Pub. L. No. 111-148, 124 Stat. 119, enacted on March 23, 2010 created new IRC Section 501(r) which applies to tax-exempt hospital organizations and their hospital facilities. IRC Section 501(r) creates the following four (4) new requirements:

1. Community health needs assessment; IRC Section 501(r)(3);
2. Financial assistance policy and emergency medical care policy; IRC Section 501(r)(4);
3. Limitation on charges; IRC Section 501(r)(5); and
4. Billing and collections; IRC Section 501(r)(6).

The proposed regulations relate to hospital requirements two, three and four outlined above. Also included in the proposed regulations is a definitions section that defines certain significant terms including gross charges, hospital organization, hospital facility and financial assistance policy. The Affordable Care Act states that a hospital organization will not meet the requirements pertaining to tax-exemption as set forth in IRC Section 501(c)(3) unless it meets the applicable requirements as outlined in IRC Section 501(r).

The community health needs assessment requirement ("CHNA") is not addressed in the proposed regulations. The IRS intends to provide future guidance with respect to the CHNA and various other aspects of the new IRC Section 501(r) requirements, including penalties for failure to comply. Accordingly, with respect to their CHNA, and any written implementation strategy adopted, hospital organizations may continue to rely on Notice 2011-52 issued in July of 2011, on or before six (6) months after the date further guidance is issued by the IRS.

Proposed Regulations

The proposed regulations define a hospital organization and offer explanations and guidance as to organizations operating more than one hospital facility, foreign hospital facilities and a hospital organization that operates a hospital facility through a disregarded entity (single member limited liability company). The proposed regulations define a hospital organization as: "(i) an organization that operates a facility required by a state to be licensed, registered, or similarly recognized as a hospital; and (ii) any other organization that the Secretary determines has the provision of hospital care as its principal function or purpose constituting the basis for its exemption under IRC Section 501(c)(3)." Hospital organizations operating more than one hospital facility need to meet the requirements of IRC section 501(r) separately with respect to each hospital facility.

The proposed regulations have defined the term "state" for these purposes to include only the 50 states and the District of Columbia. With respect to organizations which operate hospital facilities outside of the United States, a facility located outside of the United States will not be considered a hospital facility for these purposes. However, it is intended by the IRS that a hospital organization that operates a hospital facility through a disregarded entity within the 50vvv states or District of Columbia comply with IRC Section 501(r).

IRC Section 501(r)(4) Proposed Regulations: Financial Assistance Policy and Emergency Medical Care Policy

The IRC Section 501(r)(4) proposed regulations provide that a tax-exempt hospital organization must have a written financial assistance policy ("FAP") for its hospital facility(ies) which should include the following:

- Financial assistance eligibility criteria and whether that assistance includes free or discounted care;
- The basis for calculating the amounts charged to patients;
- The method for applying for financial assistance;
- If the hospital facility does not have a separate billing and collections policy, actions for an organization to take in the event of nonpayment, including collections actions and reporting to credit agencies; and
- Publicizing the FAP within the community served.

Each hospital facility must post its FAP on its website and make paper copies available upon request without charge, notify visitors via a public display and notify the community through means likely to reach individuals requiring assistance. The paper copies of the FAP must be available in both English and in the primary language of any population which constitutes more than 10 percent of the residents of the community served by the hospital facility. Additionally, the hospital facility must ascertain the method or methods best used to inform and notify residents of the community served by the hospital facility who are most likely to utilize the hospital facility's financial assistance. The FAP must also be adopted by the hospital's governing body, a committee with authority to approve and adopt on behalf of the governing body or other parties authorized by the governing body to act on its behalf.

IRC Section 501(r)(5) Proposed Regulations: Limitation on Charges

The IRC Section 501(r)(5) proposed regulations provide that a hospital organization must limit the amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under the organization's financial assistance policy ("FAP-eligible individuals") to not more than the amounts generally billed to individuals who have insurance covering such care ("AGB"). IRC Section 501(r)
(5)(B) prohibits the use of gross charges, which per the proposed regulations are defined as "a hospital's full, established price for medical care that the hospital facility consistently and uniformly charges all patients before applying any contractual allowances, discounts or deductions." Note, however, that the proposed regulations further clarify that including the gross charges on hospital bills as the starting point to which various contractual allowances, discounts or deductions are applied is permissible as long as the gross charges are not the actual amount a FAP-eligible individual is expected to pay.

Determining AGB

There are two methods outlined in the proposed regulations that hospitals may elect to use to determine AGB. According to the proposed regulations, these two methods are mutually exclusive. Once a hospital facility chooses a method it must continue to use that method. In addition, the hospital facility must calculate its AGB percentage(s) at least annually and begin applying its AGB percentage(s) by the 45th day after the end of the 12 month period the hospital facility used in calculating the AGB percentage(s). The proposed regulations also provide guidance on what constitutes a safe harbor for certain charges in excess of AGB.

The proposed regulations provide that the FAP must state which of the permitted methods a hospital facility chooses to calculate their AGB and AGB percentage. The IRS and Treasury recognize that reissuing the FAP annually to include the revised AGB percentage would be burdensome to a hospital facility. As such, the proposed regulations currently permit a hospital facility to widely-publicize its FAP noting that certain information, such as the AGB percentage, may be obtained separately from the FAP. Note, however, that the FAP still needs to include how members of the community can readily obtain this information free of charge.

1. Look-Back Method

The first method is called the Look-Back Method which allows a hospital to elect one of two alternatives to calculate AGB. These alternatives allow a hospital to calculate AGB by either (1) Medicare fee-for-service only or (2) Medicare fee-for-service together with all private health insurers paying claims to the hospital facility.

A hospital determines its AGB by multiplying its gross charges for the care provided by one or more percentages, which the proposed regulations define as AGB percentages. The AGB percentages are calculated by dividing the sum of all claims that have been paid in full to the hospital facility by the sum of the associated gross charges for those claims in the prior twelve month period. Under the proposed regulations, a hospital facility may include in "all claims that have been paid in full" both the portions of the claims paid by Medicare or the private insurer and the associated portions of the claims paid by Medicare beneficiaries or insured individuals in the form of co-insurance, co-payments, or deductibles.

Under the look back method, a hospital facility may calculate AGB by applying one average percentage of gross charges for all emergency and other medically necessary care provided by the facility. Alternatively, a hospital facility may calculate multiple AGB percentages for separate categories of care, (such as inpatient and outpatient care, or care provided by different departments) or for separate items or services, as long as the hospital facility calculates AGB percentages for all emergency and other medically necessary care provided by the hospital facility.

2. Prospective Medicare Method

The second method is called the Prospective Medicare Method which requires a hospital facility to estimate the amount it would be paid using the same billing and coding process as if the FAP-eligible individual were a Medicare fee-for-service beneficiary for the emergency or other medically necessary care provided.

The hospital facility determines the AGB for the care provided at the amount that Medicare and the Medicare beneficiary together would be expected to pay for the care. Under the proposed regulations a hospital facility may include both the amount anticipated to be paid from both Medicare and the associated portions of the claims paid by Medicare beneficiaries in the form of co-insurance, co-payments, or deductibles.

Under both the Look-Back Method and the Prospective Medicare Method, the proposed regulations provide that "for purposes of determining AGB, amounts paid under Medicare only include amounts paid under "Medicare fee-for-service," which is defined as including only Medicare Part A and Part B and excluding Medicare Advantage (or Medicare Part C)."

IRC Section 501(r)(6) Proposed Regulations: Billing and Collections

Hospital organizations are required under IRC Section 501(r)(6) to engage in reasonable efforts to determine whether an individual is eligible for assistance under its FAP before engaging in extraordinary collection actions ("ECA"). A hospital facility will be considered to engage in ECA against an individual if the hospital facility engages in ECA against any other individual who has accepted or is required to accept responsibility for the first individual's hospital bills. In addition, a hospital facility will be considered to engage in ECA against an individual if an organization purchases the individual's debt or a debt collection agency or other party to which the hospital facility has referred the individual's debt engage in ECA against the individual.

Extraordinary Collection Actions

Under the proposed regulations, ECA include any actions taken by a hospital facility that require a legal or judicial process in an attempt to collect payment from an individual covered under the organization's FAP. ECA that require legal or judicial process include, but are not limited to:

1. Placing a lien on an individual's property;
2. Foreclosing on an individual's real property;
3. Attaching or seizing an individual's bank account;

(Continued on page 20)
account or any other personal property;
4. Commencing a civil action against an individual;
5. Causing an individual’s arrest;
6. Causing an individual to be subject to a writ of body attachment; and
7. Garnishing an individual’s wages.

The proposed regulations also provide guidance on what constitutes reasonable efforts for a hospital facility in complying with this requirement.

Notification Period and Application Period

The proposed regulations provide that a hospital facility must comply with both the notification period and the application period in order to be in compliance with IRC Section 501(r)(6).

1. Notification Period

The notification period is the period during which the hospital facility must notify an individual regarding the FAP. The proposed regulations define this period as "the period begins on the date care is provided to the individual and ends on the 120th day after the hospital facility provides the individual with the first billing statement for care". Once the hospital facility has satisfied the notification requirements and if the individual does not submit a FAP by the end of the notification period, the hospital facility may engage in ECA against the individual.

2. Application Period

The proposed regulations also require compliance with an application period. A hospital facility must still accept and process FAP applications submitted by an individual during the "application period" which ends on the 240th day after the hospital facility provides the individual with the first billing statement for care. When an individual submits a complete FAP application during the application period, the hospital facility will be deemed to have made reasonable efforts to determine if the individual is FAP-eligible only if the hospital facility does the following in a timely manner: (1) suspends any ECA against the individual; (2) makes and documents a determination as to whether the individual is FAP-eligible and (3) notifies the individual in writing if they are FAP-eligible and provides them with the hospital facility’s basis for this determination.

The proposed regulations also provide guidance regarding situations relating to (1) incomplete FAP applications during the application period and (2) agreements between the hospital facility and other parties whereby the hospital facility refers or sells an individual's debt to another party during the application period.

Comment Period and Effective Dates

Comments and requests for a public hearing must be received by the IRS no later than September 24, 2012. Comments specific to the collection of information must be submitted to the IRS no later than August 27, 2012. The proposed regulations under IRC Section 501(r)(4) through 501(r)(6) released on June 22, 2012 apply to taxable years beginning on or after the date these regulations are published as either final or temporary regulations in the Federal Register.

Additionally, the effective date of the IRC Section 501(r) requirements, with the exception of the community health needs assessment, IRC Section 501(r)(3), applies to taxable years beginning after March 23, 2010, the date of the enactment of the Affordable Care Act. Thus tax-exempt hospitals should have already been in compliance with the initial IRS guidance. The community health needs assessment requirements are effective for taxable years beginning after March 23, 2012.

Summary

This article is intended to highlight the general provisions of the proposed regulations. The proposed regulations are 94 pages in length; thus a complete analysis of the proposed regulations is too comprehensive for this article. Accordingly, each hospital organization should review these proposed regulations themselves in conjunction with their current written policies and business practices in these areas for each of their hospital facilities. Based upon this review, a tax-exempt hospital organization may need to make certain revisions, additions and/or deletions to its current written policies prospectively in order to comply.

Lastly, hospital organizations should review their written policies and current business practices again upon the issuance of either temporary or final IRC Section 501(r) regulations and make revisions, if necessary.

About the Authors

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WS+B’s healthcare services group specializes in providing tax, accounting and auditing and consulting services to integrated healthcare delivery systems, hospitals and medical centers, long-term care and assisted living facilities, foundations, supporting organizations, physician groups and other healthcare organizations. WS+B’s healthcare services group currently provides healthcare services throughout the northeast, including New Jersey, New York, Pennsylvania and Rhode Island.

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• Member discounts for ANI: The HFMA National Institute, MAP Event, seminars, conferences, online courses and forums, and many products and services
• Free CPE’s available
• And much more
# Welcome Winter 2012 New Chapter Members

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<tr>
<th>Name</th>
<th>Title</th>
<th>Organization</th>
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<tr>
<td>Liz Brunell</td>
<td>PFS Team Leader</td>
<td>Northwestern Medical Center</td>
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<td>Thomas Dehler</td>
<td>Sr. Staff Accountant</td>
<td>Fletcher Allen Health Care</td>
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<td>Ryan Desmond</td>
<td>Sr. Accountant</td>
<td>Lawrence General Hospital</td>
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<td>Muliya Halchenko</td>
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<td>Dartmouth Hitchcock Medical Center</td>
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<td>Donella J. Lubelczyk, RN</td>
<td>Manager of Case Management and Revenue Cycle</td>
<td>Catholic Medical Center</td>
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<td>Elizabeth Tavano</td>
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<td>CHAN Healthcare, LLC</td>
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By Diane Blaha

~ Certified Healthcare Finance Professionals (CHFP) ~

Certifications and licenses are time-bound attestations of professional skill in that they confirm the holder's current of knowledge and skills with professionally defined standards. HFMA certifications attest that the practitioner is skilled and current with their knowledge of healthcare finance. They bring a commitment to the healthcare industry!

Congratulations are extended to five members that have earned their CHFP credentials. Please join in and congratulate these members on their accomplishment.

Carol Barrett, Elliot Hospital
Michael Counter, VNA & Hospice
Marilyn Olejnik, Porter Hospital
Steven Plant, Cottage Hospital
Jane Piotrowski, Dartmouth College

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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 Eric Walker at: ewalker@cmc-nh.org if you’re interested in learning more!

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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.