hfma
new jersey chapter

Fall 2021 • vol 68 • num 1

garden state focus
national excellence award winner

Welcome BACK to the 45th Annual Institute October 6-8, 2021 We've missed you!

Socialize Safely with Us at the Annual Institute!

The Wednesday Night Charity Event features the popular tricky tray and new 50/50 to support the NJ Sharing Network.

Thursday's President's Reception is outdoors at Borgata's Beer Garden.

And the Thursday Late Night Event at Premier features a Speakeasy theme, bringing live vintage swing jazz musicians together with other entertainment, including a magician, tarot card reader and a photo station!

Make lasting memories with your friends and colleagues at this years' Annual Insitute!

focus •advertisers•

ARMC & BPS Strategies

CBIZ KA Consulting Services, LLC

Fox Rothschild, LLP

Withum Smith+Brown

focus •cover•

Cover Courtesy of
Hermitage Press, Inc.

focus •points•

focus •features•

Who's Who in the Chapter 2021-2022

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

Communications Committee

Brian Herdman, Director .....CBIZ KA Consulting
Scott Besler, Chair ..... Toyon Associates
Adam Abramowitz.....CBIZ KA Consulting
Teresa Bailey ..... Penn Princeton
Rachel Gisser.....WithumSmith + Brown, P.C.
Laura Hess, FHFMA ..... NJHFMA
Elizabeth Litten, Esq. ..... Fox Rothschild, LLP
Amina Razanica.....New Jersey Hospital Association
James A. Robertson, Esq. .....Greenbaum, Rowe, Smith & Davis LLP
Lisa Weinstein..... Bancroft

NJ HFMA Chapter Officers

President, Jill Squiers .....AmeriHealth New Jersey
President-Elect, Brian Herdman .....CBIZ KA Consulting
Treasurer, Heather Stanisci..... Arcadia Recovery Bureau
Assistant Treasurer, Heather Weber ..... Baker Tilly LLP
Secretary, Maria Facciponti .....Elite Medical Receivables Solution

NJ HFMA Board Members

Jonathan Besler.....BESLER
Scott Besler .....Toyon Associates
Michael Costa – Ex-Officio .....DocGo
Alex Filipiak – Associate Board Member.....RWJ Barnabas
Jason Friedman .....Hackensack Meridian Health
Michael George.....Pricewaterhousecoopers LLP
Jane Kaye .....Healthcare Finance Advisors
Kim Keenoy – Associate Board Member .....Bank of America
Dave Murray ..... Richmond University Medical Center
Fatimah Muhammad – Associate Board Member ..... Saint Peter's University Hospital
Amina Razanica, CHFP..... New Jersey Hospital Association
Nicole Rosen ..... Acadia Professional
Roger Sarao, CHFP – Ex-Officio .....New Jersey Hospital Association
Lisa Schaaf..... Children's Specialized Hospital
Hayley Shulman.....WithumSmith + Brown, P.C.

NJ HFMA Advisory Council

Stacey Medeiros.....Penn Medicine
Michael McKeever..... Retired
Erica Waller ..... Penn Princeton
Scott Mariani ..... WithumSmith + Brown, P.C.

DEADLINE FOR SUBMISSION OF MATERIAL

Issue Date	Submission Deadline
Fall	August 15
Winter	November 1
Spring	February 1
Summer	May 1

IDENTIFICATION STATEMENT

Garden State "FOCUS" (ISSN#1078-7038; USPS #003-208) is published bimonthly by the New Jersey Chapter of the Healthcare Financial Management Association, c/o Laura A. Hess, FHFMA, Chapter Administrator, NJ Chapter, P.O. Box 6422, Bridgewater, NJ 08807

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

OBJECTIVE

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

EDITORIAL POLICY

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

The Communications Committee reserves the right to accept or reject contributions whether solicited or not. All correspondence is assumed to be a release for publication unless otherwise indicated. All article submissions must be typed, double-spaced, and submitted as a Microsoft Word document. Please email your submission to:
Scott Besler
scott.besler@atlanticare.org

REPRINT POLICY

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

The President's View . . .

Jill Squiers

It's no secret that I'm thrilled to have the 45th Annual Institute meeting live, in-person, after the challenging year we've had! With the opportunity to obtain 17 continuing education credits, and the return of favorite speakers plus new voices, this year's event promises to be the homecoming we all need.

In keeping with the theme adopted by HFMA's national chair to be Bold. Better. Brighter, this year's Institute is returning with new features, some borne for safety reasons and others to keep the event fresh. Our Thursday Late Night at Premier is reconstituted with a Speakeasy theme, bringing live vintage swing jazz musicians together with other entertainment, including a magician, tarot card reader and a photo station where you can make lasting memories with your friends and colleagues. Our Charity Event will feature our popular tricky-tray raffle supported with generously donated gifts from our sponsors as well as a first-ever 50/50 raffle, with proceeds from both raffles benefiting the NJ Sharing Network, a non-profit federally designated organization responsible for the recovery and replacement of donated organs and tissue for those in need of a life-saving transplant. The President's Reception on Thursday will be outdoors in the Borgata's Beer Garden, weather permitting, and we're eager to give this new venue a whirl.

I'm especially grateful to our sponsors, old and new, whose support is essential to the success of this event. We recognize that this year was an exercise in "will we or won't we" go live, and we're excited that these sponsors are able to join us as we most definitely "will." Their support also helps the Chapter host other education and networking events throughout the year.

The full Institute agenda, articles from selected speakers plus information about our sponsors is available within these pages. A full explanation of the safety measures implemented for this year's event is available on the Institute website at http://www.njhfmainstitute.org/covid.html

The members of the Institute Committee have gone above and beyond this year, engaging with each other and the leadership team to come up with new ideas to accommodate our need to safely host our featured networking events and provide meaningful education. For keeping us on track when the challenges sometimes seemed insurmountable, a special thank you to Chair Maria Facciponti and Co-Chairs Brian Herdman and Stacey Medeiros, with Sandra Gubbine at the helm for the demanding task of finding the right mix of speakers for our education schedule. Heather Stanisci gets a special shout-out for her development of the promotional flyers you've seen come across your inbox and on social media. I'd be remiss if I didn't also recognize our Chapter's administrator Laura Hess, who tirelessly keeps things running for the Institute and all year long.

Please join me at this year's Annual Institute!

Jill A. Squiers

From The Editor . . .

Scott Besler

Welcome to the 45th Annual Institute. "*What a long, strange trip it has been*" to finally be together. I am sure we each *grateful* to be here at the Borgata celebrating this event. On behalf of the communications committee, I thank you for all you have done for the chapter over the past year. I thank our Chapter President Jill Squires as well as Maria Facciponti, Stacey Medeiros, Brian Herdman, and the members of the Institute Committee for their tireless efforts in planning this event. Each week it seemed like we were shifting from a virtual to an in-person event. I also thank Sandy Gubbine for being flexible with our speakers and contributors to this event/issue.

I look forward to the energy that chapter members bring to this event and appreciate that you may be asked to plan accordingly with the wearing of masks and social distancing. We will all do our best to adjust and adapt during our time at this event. Being part of this industry for many years has taught me that if any group can "shift on the fly" it is this group. We thank you in advance for your patience.

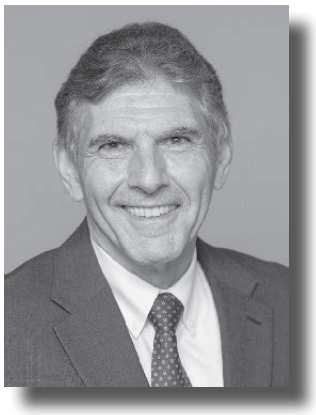
We have many interesting topics contained in this edition. In years past other chapters have embraced analytics in various sessions and webinars, Analytics as Your Strategic Partner is an article that discusses what many hospitals have known in that data and analytics affect decisions and create opportunities. Jo Surpin's article also discusses analytics and how they can help align incentives for physicians and hospitals. Ed Eichhorn discusses the pandemic and the steps we need to take (and listen) to get through it. As always with this edition we strive to include different types of articles – articles that discuss risk management, financial sustainability, as well as revenue cycle and billing. Threats to our daily business leads us to understand more from the issues surrounding as Cyber-Security as well as Fraud and Abuse. These issues seem even more prevalent than in years past. There are also articles that discuss how hospitals throughout the country have fared with the challenges of their S-10 audits as well as submissions of their CARES funding – it seems for both call for additional guidance.

In closing, I hope you make the time to attend the general session where Sandra Lane presents, *Stop Procrastinating & Start Producing*. For a personal example I am grateful for the cost report extensions that CMS gave to hospitals over the past year and a half. Although it did seem like we were still pressed for time to meet the deadline. We thank you for your continued participation in our chapter and hoping we all "*meet up in Atlantic City*."

Thank you.

Scott

Analytics as Your Strategic Partner



John Nettuno

by John Nettuno

Summary

Health care is expensive in the U.S. In fact, the cost is twice as much per person compared to other wealthy countries. Health spending per person in the U.S. was **$10,966 in 2019**, which was 42% higher than Switzerland, the country with the next highest per capita health spending. (Source: KFF analysis of OECD National Health Expenditure data).

Because healthcare is so expensive in the U.S. compared to other countries, and because its cost is such a political concern, there is tremendous pressure on hospitals to reduce costs. Understanding those costs and increasing efficiencies is key to achieving this goal.

When properly used, analytics and data can provide a window into showing how to provide better care while lowering costs, improving the patient experience and satisfaction, and differentiating services by showing valuable metrics.

The use cases that follow are based on the author's experiences. They are suggestions to consider. The best use cases develop from an organization's requirements. As a result, they should satisfy the unique needs of the particular hospital.

This article makes the case that analytics should be a core business function like Finance and Operations because it should provide guidance and solutions to problems. It also serves as measurement, a feedback mechanism, and a guide when undertaking important tasks.

The quantity of information available today demands increasing levels of advanced analytics in order to stay competitive.

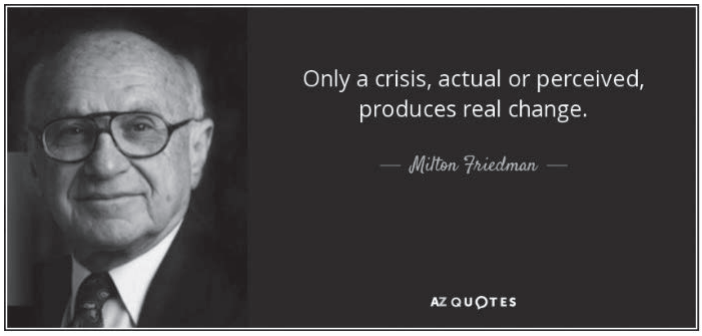
In a previous article, the author described a blueprint for building a robust analytical platform. It can be found on page 28 of the following 2021 Summer Issue of *Focus Magazine*. (URL link: https://hfmanj.org/content.php?page=news)

This article attempts to show how analytics can be used strategically and why it should be a core department of any hospital.

Done properly, analytics is your best friend. Improperly, your worst enemy.

Overview

Milton Friedman said that only crises produce real change. Covid-19 certainly provided a crisis.



Hospital operations have changed dramatically during the past 18 months.

When properly used, analytics and data can provide a window into showing how to provide better care while lowering costs, improving the patient experience and satisfaction, and differentiating services by showing valuable metrics.

It has affected virtually all areas including those important areas of revenue generation, regulations, quality of care, and employee relations.

The speed of this change requires more and faster decisions. Good analytics assists in this area.

Hospitals need tools and approaches that provide faster and cheaper analytical solutions.

There is a multitude of use cases for analytics within their operations.

Decisions and Analytics

Change presents opportunities.

Making good decisions during these times is a hallmark of leadership. Most people freeze or underreact during a crisis as the emotion of fear takes over.

Data-driven decision-making (DDDM) is defined as using facts, metrics, and data to guide strategic business decisions. It provides the ability to understand what works and what does not in a business environment.

Solutions to problems require time, money and resources. Analytics can reduce the resources required by providing a path to move forward, and a well-managed analytics process has a multiplier effect on efficiency.

Let us define what questions analytics answers:

The accepted definition of data analysis types and the questions they answer are as follows*:

- Level one – Descriptive data analysis: What happened?
- Level two – Diagnostic data analysis: Why did it happen?
- Level three – Predictive data analysis: Where are we going?
- Level four – Prescriptive data analysis: What is the best way forward?

* Source: Gartner and others

Level one is reporting. Levels two, three, and four are increasing levels of analytics, with increasing levels of difficulty to achieve, but offering increasing levels of decision support.

Time is always critical. The flow of information is so fast that data can become obsolete quickly. The quote about timely data that stock traders like to quote is, "If you trade the news, you lose."

It is a good idea to start simply, focus on a basic warehouse platform, and build upwards.

Critical information may be useless tomorow. This not only applies to trading but also applies to patient deterioration measures where a late data can be castastropic.

When you want the best information, the challenge almost always comes down to, "How do I get it?"

Data should always be gathered from its original source. Information changes from when moved and affects the decisions and assumptions made on it.

Use Cases and Examples

Departments already run many clinical, quality and financial reports telling them what happened yesterday. Our goal is to take this work to the next level. We want to work better, faster, and smarter.

Let us look at some ways to achieve his.

Assumptions can be made by using "What if" scenarios. Estimates of minimum and maximum values for revenue targets, expense reduction, new patients and endeavors can lead to new approaches to old problems. These can be displayed graphically to show a range of results.

Simulated results should be used for funding, grants, contract negotiations and other ways to raise money or lower expenses.

Strategic planning focuses on key executive initiatives. The key metrics to achieve these goals should come from planning meetings. These metrics should use data from proprietary or public data, existing databases, assumptions, or other important sources in their algorithms.

Executive management should strive to request prescriptive or predictive answers.

I have listed below examples of areas that are frequently key to corporate goals. The intention is to get the reader interested in and focused on areas that would benefit from using better analytics. All issues listed can be analyzed differently and have multiple solutions.

Better analytics leads to a better solution.

Business and Financial Examples

- Optimize ways to increase revenue. Compare the value of acquiring new patients to cost of acquiring them.
- Rank departments using an efficiency formula based on departmental goals
- Reduce "Discharged Not Final Billed" rate by identifying areas of concern.
- Provide proactive account receivable management.
- Preventing appointment no-shows. Reduce wait time and improve patient experience.
- Provide cost accounting metrics by department identifying departments that need management attention.
- Increase patient satisfaction metric by measuring ease of appointment scheduling, office wait time, and satisfaction with visit.
- Predict optimum staff levels based on season, holidays, and other experience factors.
- Select new locations based on patient demographics and patient travel times.
- Get control of cost centers. Supply chain management. Optimize ordering and negotiate pricing.

Quality of Care Examples

- Population Health Risk Metrics, especially for chronic diseases.
- Monitor patient's vital signs in real time and predict those with a high chance of requiring help in a specific timeframe.
- Monitor patients remotely with biometric sensors. Death from stoke can be reduced with remote blood pressure monitors. Oxygen sensors can pick up seniors in trouble.

continued on page 8

continued from page 7

- Determine patient risk of readmission.
- At home monitoring of seniors who are at risk of fall.
- Identify the highest at-risk patients for follow up before discharge. Prevent 30-day readmissions.
- Improving variation in care and outcomes.

The goal is to identify a few key areas and decide how you move forward. Next, ask your analytics department how to get there and remember this is an iterative process.

Analytics versus Reporting

It is a subtle difference, and many organizations think they do analytics when they are really just doing reporting.

Reporting takes data and turns it into useful information. Analytics takes information and turns it into insights. Reports tell you what happened. Analytics tell you why it happened.

Reporting systems are included with all transaction systems. These systems frequently provide good reporting and some level of analytics about the data they collect.

While these systems are critical to operations, the amount of information they provide can be confusing. They frequently make it difficult to interpret because there is simply too much data, and it is organized in a confusing way.

It is like trying to see the forest through the trees when you need a helicopter to see what is around you.

Simplifying the data and analyzing it with data from other systems allows better analysis. The additional data helps to create a story that provides insight.

For example, automobiles used to have a few sensors. A speedometer, an oil level and temperature gauge were all that was needed. Now, modern cars have up to 100 sensors that talk to each other. This is expected to increase to 200. Data combined with other data yields useful actionable information.

Departmental efficiencies require data from multiple systems. Data from budgeting, finance, human resources, contract management, and procurement systems may be required to answer the questions asked.

The questions everyone should ask are the following:

- Where are we going?
- What is the best path forward?

A Single Source for Data, Integrate Once and Only Once

According to Forbes magazine, data is the most ignored and valuable asset. Spreadsheets and text files are frequently the method to move it from place to place.

A single source for data makes data edits in one central location. A data warehouse, sometimes called data lakes, is the ideal place to do this.

A direct connection to the source provides access to the latest, most accurate data. It is the most secure because it is a secure connection and kept in an encrypted database. Data transferred in text files are the least secure because they are hard to track after they are created. Data in a database can always be tracked.

The process of bringing necessary details together is called integration. It involves the extraction of data from multiple systems and modeling it with other data.

Model and Reuse Data

Properly modeled data can be used repeatedly for multiple reports. This saves time and money.

The results can also be combined with other models. It takes a little more time to do it right the first time.

Some items to consider:

- Reporting and analytics is labor intensive.
- Depending on the types of model built, a single model can generate many different kinds of reports.
- You should decide how you want to aggregate and display it so it makes the most sense.
- Remember large data sets are manageable and can be aggregated to simple trends.

Integrating, modeling, and displaying data is expensive. Once it is in the proper format and loaded, you can reduce the cost of creating and re-creating similar reports by using the same data models.

Cost Considerations

Data typically resides in a data warehouse, which is simply a storage place for databases. There are several kinds of databases. The two we are most concerned with here are analytical databases and transactional databases.

Analytical databases are completely different from transactional databases like medical records or accounting systems,

which why they are separate entities. For this discussion, please think of them this way:

- Analytical Databases – small number of large spreadsheets that are designed for calculations.
- Transactional Databases (Human Resources, Electronic Medical Records, Financial applications) – large number of smaller spreadsheets that are designed for speed.

Analytical databases are designed to make it easy and less expensive to analyze data from multiple perspectives.

Because their designs goals are completely different, these are always separate database***s.***

Analytic systems require data from multiple sources. It is good practice is to get that data from the original source. Hint: It saves money!

The major costs considerations are analytical software, the infrastructure, and staff.

There are many software solutions with a wide range of pricing, and many smaller companies offer excellent low-cost systems.

Gartner Inc., a global research company, rates software and business intelligence platforms. They rate the top 20 company's tools in this area. Their analysis includes all major platforms with their strengths and weaknesses. I suggest this list if you are looking at vendors.

Virtually all platforms listed in their reviews are capable of analyzing large quantities of data and are serious competitors in the marketplace.

You will need the following functionality to do analytics:

- A database
- An ETL package
- A reporting tool
- An analytics platform

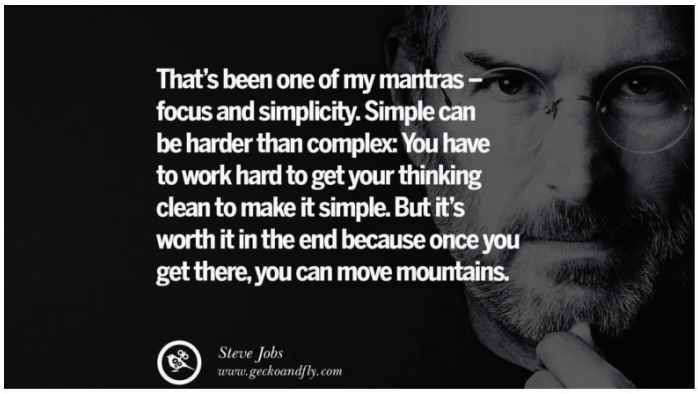
Some toolsets are complete platforms, which handle everything from database to integration, including transformation and displaying of data.

From a monetary point of view, the fewer tools you require and the simpler the process, the lower your cost.

It is a good idea to start simply, focus on a basic warehouse platform, and build upwards. This will offer the ability for you to:

- Own your data
- Base decisions on the level of analysis you require.
- Make sure you use timely data to support decisions.
- Present the data in a clearly understandable form.
- Make (wise) decisions based on your analysis.

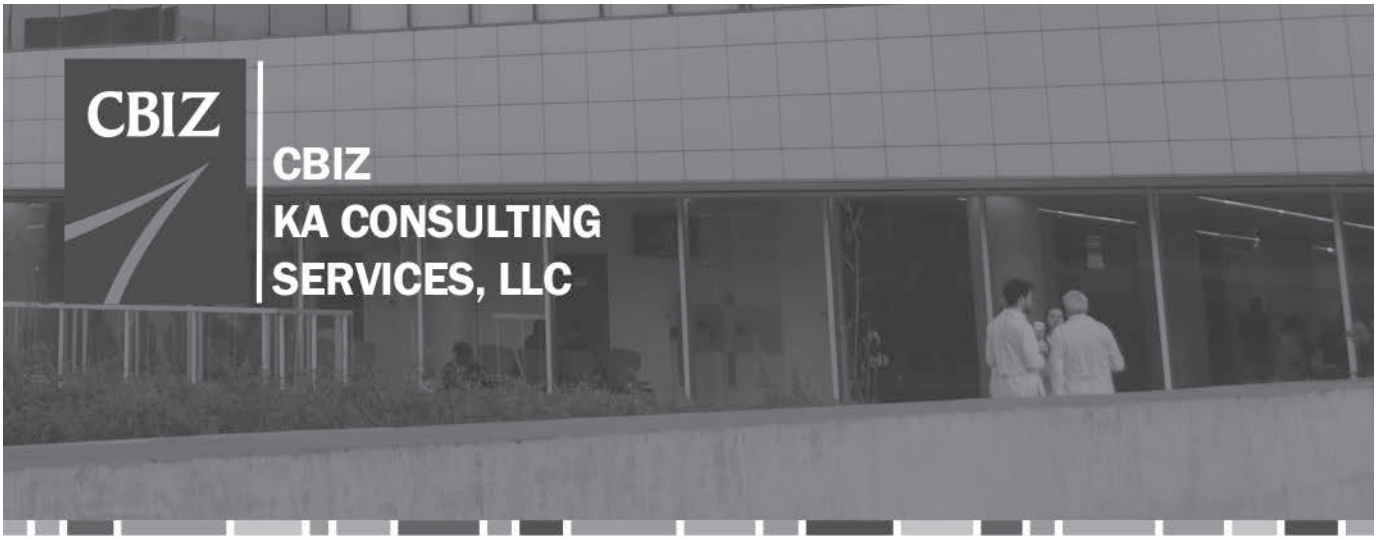
Steve Jobs said it correctly!



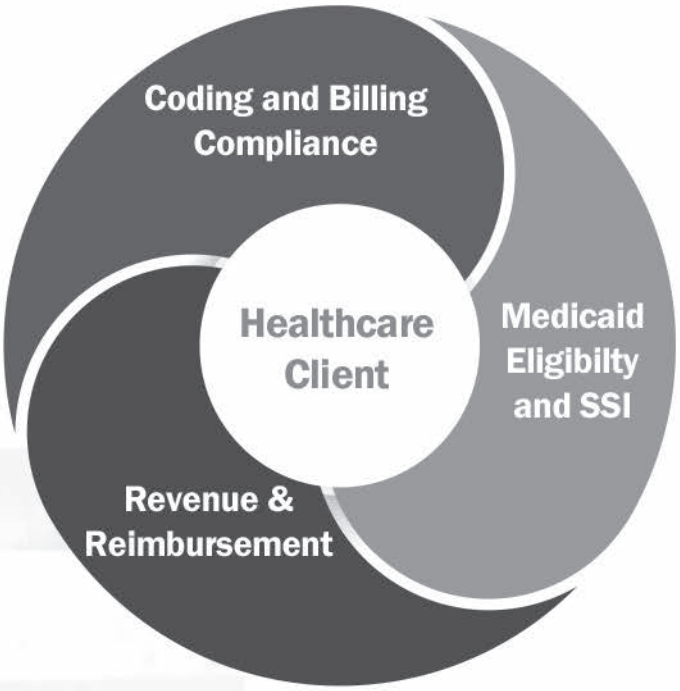
** All images use in accordance with the Fair Use policy of Media Law. They are for educational purposes only, and no infringement of copyright is intended. Their respective owners retain all copyrights.

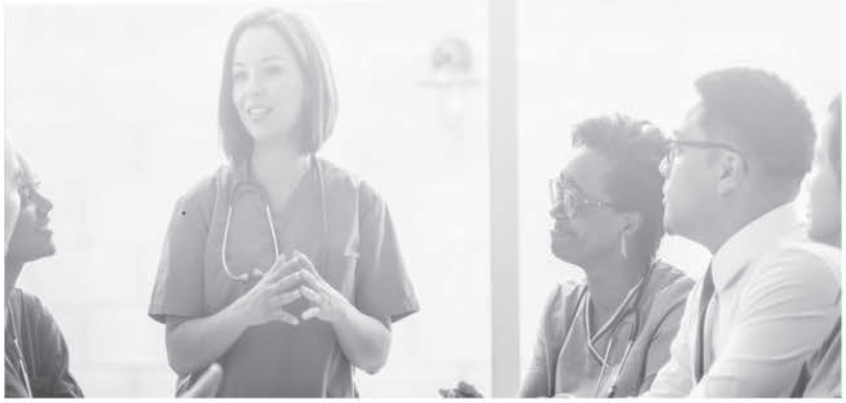
About the Author

John Nettuno is Manager of Enterprise Analytics & Information Technology at St. Joseph's Healthcare. He can be reached at nettunoj@sjhmc.org.



Since 1978, CBIZ KA Consulting Services has partnered with New Jersey healthcare providers to deliver critical solutions producing results that have meaningful value.





www.kaconsults.com

Connect with us

Adam Abramowitz,
Senior Manager, Sales and Marketing

aabramowitz@cbiz.com
609-918-2093 x 169

The Value of Participation

Michael McKeever

by Michael P. McKeever, CPA, FHFMA

Membership in HFMA, whether as an individual or through an Enterprise relationship, brings a great deal of value in that it provides access to educational opportunities across the broad spectrum of healthcare practice as well as the ability to enhance your network of contacts through our ongoing networking events. Even the pandemic didn't slow us down in our efforts to reach our members, as the ongoing webinars, virtual sessions and interesting new networking events showed. But to fully realize the value of membership I'd strongly suggest becoming engaged with one of the many committees and focus groups available to all NJ HFMA members. And please feel free to invite your non-member colleagues to join us, as once they see the quality of our offerings we hope that they will consider joining HFMA.

The NJ Chapter has two types of committees that have different focuses, one group that are administrative in nature and the other that are practice specific. Under the administrative umbrella we have the Communications Committee, the Education/Certification Committee, the Annual Institute Committee, and the Membership Services and Networking Committee. Those that focus on specific areas of practice are the Compliance Audit Risk and Ethics Forum (CARE), Finance Accounting Capital and Tax Forum (FACT), Payer and Provider Collaboration Committee (P2C2), Patient Access Services Forum (PAS), Patient Financial Services Forum (PFS), Physician Practice Issues Forum, Regulatory and Reimbursement Forum (R&R) and the Revenue Integrity Committee. Below I'll give a short synopsis of the work of the various committees and forums. For more information please click on the Committees tab on the Chapter's website. There you'll find the schedule for the meetings and contact information.

The **Communications Committee** develops and publishes the Chapter's news magazine, the Garden State Focus, soliciting articles from the membership, committees and outside sources. This includes information regarding Chapter and Association activities, in order to keep our members informed. In addition, the committee maintains the Chapter's website.

The **Education/Certification Committee** provides ongoing education through webinars and special in-person events. They are also responsible for establishing the agenda for the Annual Institute. The NJ Chapter, through the Education/Certification committee also collaborates with other HFMA Chapters as well as unaffiliated entities in their quest for topics of interest to our members. The committee is also responsible for increasing members' awareness of the value of HFMA certification, which is now included in our membership dues.

The **Annual Institute Committee** begins its work even before the prior year's event has ended, with the President-Elect and Chair planning for the next year's event. Meetings of the full committee typically begin in January, with the AI occurring in early October each year. All of the hard work and dedication is rewarded in that this year will be our 45th Annual Institute, with each one being memorable to those who attend.

The **Membership Services and Networking Committee** is responsible for the growth and retention of the membership of the NJ Chapter through ongoing evaluation of our member's needs. In addition, they provide various networking opportunities throughout the year to meet with colleagues from around the state for relaxation and social interaction. Of course with the pandemic this became impossible, but the committee never missed a beat, providing a number of virtual events that folks are still talking about.

The **CARE Forum** assists providers in navigating the legal and regulatory environment of healthcare through discussion of emerging issues in real time. The forum also promotes awareness of compliance, audit, risk and ethics issues while promoting best practices through the use of educational sessions and group discussion.

The **FACT Forum** focuses on those issues related to financial reporting and accounting, access to capital and taxes. Members routinely represent the finance departments of healthcare providers and those consultants and auditors with whom they collaborate.

P2C2 brings together members from both the payer and provider communities to discuss issues of interest to both parties, allowing for a better understanding of those issues and providing an opportunity for a collaborative approach in finding and implementing meaningful solutions.

The **PAS Forum** provides a venue for members of the access community to discuss issues, share ideas and develop best

continued on page 12

continued from page 11

practices, working closely with PFS, P2C2 and R&R on issues of mutual concern related to the revenue cycle.

The **PFS Forum** provides an active venue for discussions of all issues related to the revenue cycle, while increasing awareness of its contribution to the financial success of providers. The forum functions as a watchdog for managed care issues, including billing and payment trends and contract compliance issues.

The **Physician Practice Issues Forum** focuses on those issues related to physician services, whether hospital based or independent, Routine topics include operations, finance, strategic planning and compliance, as well as innovation and collaboration between physicians and other providers.

The **R&R Forum** represents the healthcare financial community in addressing issues related to proposals and changes to legislation and regulations that impact providers. In addition, the Forum consults with legislators, payers and others in order to resolve reimbursement issues.

The **Revenue Integrity Committee** is a forum for discussing issues, such as the charge reconciliation process and charge master maintenance, that are not addressed in great detail in the other forums and committees. The committee is dedicated to understanding and learning to operationalize the multitude of regulations affecting healthcare providers.

Information on the committees and forums is readily available on the Chapter's website. To fully appreciate the value of your HFMA membership I'd strongly encourage you to become involved with one or more groups that may pique your interest, either professionally or personally. There's a lot to be gained, both in knowledge and camaraderie, with literally nothing to lose.

•Focus on...New Jobs in New Jersey•

JOB BANK SUMMARY LISTING

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

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

Job Position and Organization

Financial Analyst
Panacea Healthcare Solutions, Inc.

NJ Reimbursement Specialist
Penn Medicine

Senior Analyst- Financial Planning And Analysis
BAYADA Home Health Care

Budget and Cost Analyst
Children's Specialized Hospital

Financial Analysis
RWJ New Brunswick

COVID-19 CMS Updates: Billing and Impact on Transfers

Mary Devine

by Mary Devine, RN

When the Covid-19 emergency began in March 2020, the Centers for Medicare and Medicaid Services issued a blanket waiver offering providers greater flexibility as they, and the nation, tried to cope with a global pandemic. They wanted to put patients over paperwork.

The blanket waiver touches many aspects of healthcare operations from documentation to care and discharge planning to staffing and locations of care. All of it has had wide-ranging impacts, including on the Post-Acute Care Transfer (PACT) rule. Because of the changes influencing the transfer rule, Medicare payments to hospitals have reduced by about $5 billion on an annual basis.

Let's take a look at what's been happening.

The Post-Acute Care Transfer policy states that if a patient is discharged below the geometric mean length of stay and the discharge status on the claim indicated a transfer to post-acute care, then the hospital is entitled to a per diem payment amount rather than the total amount a full DRG payment would provide.

In the early days of the pandemic, hospitals were moving non-Covid patients out of the hospital as quickly as possible in an effort to minimize spread. With shorter length of stays, hospitals bumped up against the PACT rule, which resulted in reduction in payment.

Hospitals that had a high Covid case load were not as severely impacted in this way because their Covid patients had longer stays, which meant they met the PACT rule's geometric mean length of stay metric ensuring they got full DRG payment.

However, treatment for Covid now is different than it was in the early days of the pandemic and as a result, patients are in the hospital for shorter periods, so even hospitals with higher numbers of Covid cases are running into reduced payments. The shorter the length of stay, the more likely a claim is impacted by the transfer rule.

Add to that that many Covid cases fall under respiratory DRGs and about 280 of those DRGs are impacted by the rule because these are all discharge status codes that indicate a transfer and will cause reduction in payment. So, if you are using one of these 280 or so codes, make sure that you really mean a transfer indicating that the patient is receiving post-acute care.

For example, if a patient is going home but is supposed to come back for a test, that would not be an 02; it would be an 01. Or if a patient is going to another acute care hospital for an outpatient procedure, that would be an 01. You just want to be careful that if you use any of these codes, you mean that the patient is going to be receiving post-acute care.

Another issue is inappropriate coding or not coding a discharge status, which results in rejection, overpayment or underpayment. None of which is good.

Errors in coding are easy to make with all the changes instituted by CMS' blanket waiver and other changes made by the agency since the pandemic began in order to better facilitate patient care and get people vaccinated quickly. Examples of some of those changes include:

- Allowing quarterly updates of diagnosis and treatment codes, which hasn't been allowed in the past.
- Providers can now code from a test result without physician involvement supporting the diagnosis. And residents can now bill without a teaching physician present. Modifier GE is needed in such cases.
- The list of codes relating to cost sharing and deductibles has also expanded greatly. The changes here save patients their copay and deductible charges, but must be coded with the CS modifier.
- The three-day qualifying stay before getting into a skilled nursing facility has been waived as has the minimum amount of therapy needed in the acute care setting before transfer to an inpatient rehab setting.
- And determining the right discharge code can be tricky now that CMS has opened the door to alternate care sites, which the agency did to expand capacity and service availability, and, in particular, to allow for acute hospital care at home.

continued on page 14

continued from page 13

It's important to remember that even though the blanket waiver was issued by CMS with the purpose of putting patients before paperwork, paperwork hasn't gone away, and truly, if you don't have the proper documentation or it's not accurate you are not likely to get paid appropriately.

Even though COVID-19 feels as if it is finally behind us, the blanket waiver and the Pandemic are still in place. Patients are still being treated for impacts of the virus and might still require admissions that will likely be impacted by the rule. All the impacts of the waiver remain in place until called off by the President. In addition, hospitals are seeing all those elective patients that haven't been seen for a year, which would also be subject to the rule or potential waiver items.

With all the changes brought about by the blanket waiver and the room for error associated with all that change, compliance concerns are heightened. There is now a lot of opportunity – or risk – for coding to not reflect the care provided resulting in either overpayment or underpayment.

In the past year the Office of Inspector General (OIG) has spent a lot of time focused on the transfer rule – auditing claims for accuracy – especially as it relates to patients discharged to their homes (01s), which puts pressure on CMS to be more vigilant and on hospitals to make sure claims are correctly coded and billed.

In 2021, these audits of transfer coding remain a focus of OIG. Hospitals want to make sure they are getting ahead of overpayments, particularly, before the OIG does. Performing in-house audits should be done when possible and as frequently as possible in order to stay ahead of OIG. Claims have to be right and they have to be accurate all the time. Whether you are overpaid or underpaid, you want to make sure your claims are correct, and if they are not, that incorrect claims are fixed.

Some things to do keep on track:

- Do not rely solely on CMS eligibility and utilization; do a clinical review. If something's coded an 03 and it wasn't intended to be an 03 – maybe it was intended to be an 02 – you won't know that without reviewing the clinical information. So, make sure you are verifying with the post-acute care provider that whatever is intended by the discharge or transfer code is actually what happened.
- Pay particular attention to claims coded with DR. You really want to make sure that you are comfortable with the discharge status of this code, because if it's a DR, that's indicating it was a disaster and there was COVID involved and you want to make sure that the appropriate discharge status is placed on that claim. Also pay more attention to the use of condition code 42 with a discharge status code of 06. This combo entitles providers to the full DRG, but there's the risk of overpayment if clinical resources are not involved to determine the appropriateness of the coding.
- Do an overpayment review. If you aren't doing an overpayment review, at least take a look to see if there is a high use of discharge codes 69 or 70. Figure out the intended use of these codes – where that patient really went and what type of care was provided. If you're not documenting why and where a patient is going, there's room for error: Insufficient documentation leads to overpayments.

About the Author

Mary has over 25 years of experience in healthcare financial management and has a wide knowledge of all components within the revenue cycle as well as a strong clinical background. Mary holds a Bachelors in Accounting from The Pennsylvania State University and is an RN.

New Members

Krishna Thakar
krishna.thakar@student.ashford.edu

Irina Tropcheva
Atlanticare
Business Manager
irina.tropcheva@atlanticare.org

Laura Braswell
Reventics
AVP Account Management
laura.braswell@reventics.com

Angela Brisotti
Atlantic Health System Inc
Reimbursement Manager
angela.brisotti@atlantichealth.org

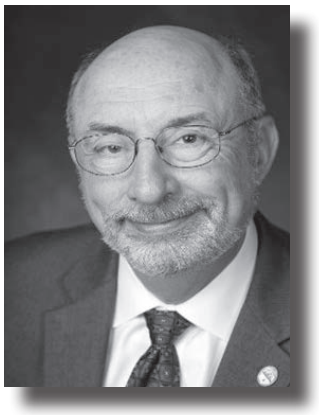
•Who's Who in NJ Chapter Committees•

2021-2022 Chapter Committees and Scheduled Meeting Dates

***NOTE:** Committees have use of the NJ HFMA conference Call line.
If the committee uses the conference call line, their respective attendee codes are listed with the meeting date.
PLEASE NOTE THAT THIS IS A PRELIMINARY LIST - CONFIRM MEETINGS WTH COMMITTEE CHAIRS BEFORE ATTENDING.

COMMITTEE	PHONE	DATES/TIME/ ACCESS CODE	MEETING LOCATION
CARE (Compliance, Audit, Risk, & Ethics)			
Chair: Danette Slevinski – danette.slevinski@gmail.com	(516) 617-1421	First Thursday of the month	Conference Call
Co-Chair: Leslie Boles – lboles21@gmail.com	(732) 877-9864	9:00 AM	(712) 770-5393
Board Liaison: Fatimah Muhammad – fmuhammad@saintpetersuh.com	(732) 745-8600 Ext. 8280	Access Code: 473803	
Communications / FOCUS			
Chair: Scott Besler **(Editor)** – scott.besler@toyonassociates.com	(732) 598-9608	First Thursday of each month	Conference Call (712) 775-7460
Board Liaison: Brian Herdman – bherdman@cbiz.com	(609) 918-0990 x131	10:00 AM Access Code: 868310	In-person Meetings by Notification
Education			
Chair: Hayley Shulman – hshulman@withum.com	(973) 532-8885	Second Friday of the Month	Zoom Meeting
Co-Chair: Sandra Gubbine – Sandra.Gubbine@atlanticare.org	(609) 484-6407	9:00 AM	(646) 876-9923
Co-Chair: Lisa Weinstein – lisa.weinstein@bancroft.org	(856) 348-1190	Access Code: 89425417190	via Zoom
Board Liaison: Kim Keenoy – kim.keenoy@bofa.com	(732) 321-5935		
Certification (Sub-committee of Education)		See Schedule for	
Chair: Amina Razanica – arazanica@njha.com	(609) 275-4029	Education Committee	
Board Liaison: Chair: Amina Razanica – arazanica@njha.com	(609) 275-4029		
FACT (Finance, Accounting, Capital & Taxes)			
Chair: Alex Filipiak – Alexander.Filipiak@rwjbh.org	(732) 789-0072	Third Wednesday of each month	Conference Call
Co-Chair: Hanna Hartnett – Hanna.Hartnett@atlentcare.org	(609) 569-7419	8:00 AM	(872) 240-3212
Board Liaison: Dave Murray – dmurray@rumcsi.org	(856) 298-6629	Access Code: 720-430-141	via GoToMeeting
Institute 2021			
Chair: Maria Facciponti – facciponti.maria@gmail.com	(973) 583-5881	Third Monday of each month	Conference Call
Co-Chair: Brian Herdman – bherdman@cbiz.com	(609) 918-0990 x131	2:00 PM	(712) 770-4957
Co-Chair: Stacey Medeiros – Stacey.Medeiros@pennmedicine.upenn.edu	(609) 423-8731	Access Code: 865290	
Board Liaison: Maria Facciponti – facciponti.maria@gmail.com	(973) 583-5881		
Membership Services/Networking			
Chair: Nicole Rosen – nrosen@acadia.pro	(862) 325-5906	Third Friday of each month	Conference Call
Co-Chair: John Byrne – JByrne56@gmail.com	(917) 837-2302	9:00 AM Access Code: 267693	In person Meetings
Board Liaison: Heather Stanisci – hstanisci@ArcadiaRecovery.com	(862) 812-7923	(712) 770-5335	by notification
Patient Access Services			
Chair: Daniel Demetrops – ddemetrops@medixteam.com	(845) 608-4866	Second Thursday of each month	Conference Call
Co-Chair: Jacqueline Lilly – jacqueline.lilly@atlanticare.org	(609) 484-6408	at 4:00PM	(712) 770-5377
Board Liaison: Amina Razanica – arazanica@njha.com	(609) 275-4029	Access Code: 196273	
Patient Financial Services			
Chairman: Ruby Ramos – ruramos77@yahoo.com	(908) 884-7259	Second Friday of each month	Conference Call
Co-Chair: Steven Stadtmauer – sstadtmauer@csandw-llp.com	(973) 778-1771 x146	10:00 AM	(712) 770-4908
Co-Chair: Maria Facciponti – maria.facciponti@elitereceivables.com	(973) 583-5881	Access Code: 120676	
Board Liaison: Maria Facciponti – facciponti.maria@gmail.com	(973) 583-5881		
Payer/Provider Collaboration			
Chair: Tracy Davison-DiCanto – tracy.Davison-DiCanto@scasurgery.com	(609) 851-9371	Contact Committee	
Board Liaison: Lisa Maltese-Schaaf – LMaltese-Schaaf@childrens-specialized.org	(732) 507-6533	for Schedule	
Physician Practice Issues Forum			
Chair: Michael McLafferty – michael@mjmaes.com	(732) 598-8858	Third Wednesday of the Month	In person Meetings
Board Liaison: Erica Waller – erica.waller@pennmedicine.upenn.edu	(609) 620-8335	8:00AM	with call in available
			via WebEx (Contact Committee)
Regulatory & Reimbursement			
Chair: Jason Friedman – Jason.friedman@atlantichealth.org	(973) 656-6951	Third Tuesday of each month	Conference Call
Co-Chair: Chris Czvornyek – chris@hospitalalliance.org	(609) 989-8200	9:00 AM	(712) 770-5354
Board Liaison: Scott Besler – scott.besler@toyonassociates.com	(732) 598-9608	Access Code: 382856	
Revenue Integrity			
Chair: Tiffani Bouchard – tbouchard@panaceainc.com	(651) 272-0587	Second Wednesday of each month	Conference Call
Board Liaison: Jonathan Besler – jbesler@besler.com	(732) 392-8238	9:00 AM Access Code: 419677	(712) 770-5021
CPE Designation			
Chair: Lew Bivona – lewcpa@gmail.com	(609) 254-8141		

The Covid-19 Pandemic: What have we learned and where do we go from here?



Edward C. Eichhorn

by Edward C. Eichhorn

As John Dalton likes to say at the beginning of each of our Healing American Healthcare Podcasts, together we have almost 100 years of healthcare experience and we are still trying to figure it out. It's really complicated!

When Covid-19 infections began to spread in March 2020, John and I decided to form the Healing American Healthcare Coalition. Its goal is to provide physicians, nurses, and healthcare professionals with accurate and current information on healthcare issues in a concise and easy to read way. We publish an email newsletter, the Three Minute Read™ (TMR), at least twice a month. It provides readers with summaries and critiques of five or six articles from a wide range of sources. If the reader wants to read the full article, he or she simply clicks on the title to link to it.

Through June 2021, 170 articles from 64 sources were summarized. The second book in our series, ***Healing American Healthcare – Lessons Learned from the Pandemic,*** is now available at Amazon**.** Information about the Healing American Healthcare Coalition, the Three Minute Read™ and our blogs and podcasts is available at www.healingamericanamericanheathcare.org.

Based on all that we have learned over the last year and a half, I often think about and reassess what America has done well and what could have done better to bring the pandemic to an end. There were some great successes, but sadly there were some issues that could have been handled much better.

The pharmaceutical industry made incredible advances to meet the challenge of the pandemic by developing and producing vaccines in less than a year that proved to be highly effective in preventing serious Covid-19 illness and deaths. One study summarized in TMR reported that at least 279,000 lives were saved by this timely and rapid development. Currently, more than 4.5 billion inoculations have been administered around the world, primarily in wealthy nations. The U.S. and the G-7 countries have committed 1 billion doses to the United Nations for distribution through COVAX to poorer nations between now and the end of 2022.

Vaccination remains the key to bringing the pandemic under control. In the U.S. more than 352 million shots have been administered and 167 million Americans have been fully vaccinated. That's 51% of the population. To reach the 70% threshold for herd immunity another 19% of Americans need to be fully vaccinated. Currently, the Delta variant is spreading rapidly across the country, especially in states with low vaccination rates. According to the CDC, 99% of the patients that have been hospitalized due to the Delta variant were unvaccinated. Surveys show that approximately 30% of American adults are opposed to vaccination for a variety of reasons, despite the large number of successful vaccinations that have been administered and the small number of serious side effects. Conflicting messages on some social media platforms that share inaccurate or incorrect information opposing vaccination is making the road to herd immunity more difficult than it should be. That is despite the likelihood that most of those who are unwilling to be vaccinated for Covid-19 were vaccinated as children. All 50 states require that children be vaccinated to prevent diphtheria, tetanus, pertussis, polio, measles and rubella, and chickenpox. Otherwise, they cannot attend school.

Last century, the comedic duo of Abbott & Costello was frightfully funny; today, the gubernatorial duo of Abbott & DeSantis is just frightening.

The response to the challenges of providing patient care during the pandemic by America's hospitals, physicians, nurses, and support staffs has been nothing short of heroic. When the New York Metro area joined Milan and Madrid at the pandemic's epicenter from mid-March through April 2020, there were shortages of ventilators, masks, gowns. and other urgently needed supplies. Hospitals found creative ways to stretch limited supplies so that patients could be treated safely and effectively.

ICU nurses and cell phones became the sole link to their families for dying patients. As Covid-19 admissions surged, hospitals had to reduce or eliminate elective procedures. Fortunately, the use of telemedicine rapidly expanded to maintain non-Covid-19 patient care where possible. Sadly, more than 3,600 hospital workers have died from Covid-19

Dr. Frieden noted that *"Bad politics, quite simply, can trump good public health."*

The public health guidance provided at the beginning of the pandemic was clear:

- Wear a mask or face covering when out in public.
- Wash your hands frequently with soap and water for 20 seconds.
- Practice social distancing by staying at least 6 feet away from others.
- Avoid crowds.
- Cover your mouth it you sneeze or cough (then wash your hands as described above).

When the CDC issued its recommendation to wear masks when out in public, former President Trump announced that he would not be wearing one. Eventually he caught Covid-19 and at one point there were more infections among the White House staff than there were among New Zealand's 4.8 million residents.

Government Leadership Matters

The dramatic and tragic difference in patient outcomes is clearly demonstrated by comparing data for governments that chose to enforce public health guidelines and those that did not. For example, Florida has 21.4 million residents; Taiwan has 23.8 million. When the outbreak began, Taiwan reacted immediately, requiring visitor quarantines, mask-wearing, targeted testing and contact tracing. Florida, on the other hand, only sporadically implemented quarantines, masking requirements, testing and contact tracing. Through December 2020, Taiwan reported 740 Covid-19 cases and seven deaths. Florida reported 1.13 million cases and 19,865 deaths. Florida Governor Ron DeSantis continuously fought to lift restrictions on public gatherings, occupancy limits and mask requirements while blaming the rise in cases on increased testing.

Similarly, the four Scandinavian countries (Denmark, Finland, Norway and Sweden) have 27.1 million residents, close to Texas with 29.0 million. Despite Sweden's faltering start, on June 30 the Scandinavian countries' per capita fatality rate of 69.8/100,000 was far better than Texas at 180.4/100,000.

Recently, Governor DeSantis continued his opposition to masks by banning school districts from requiring students to wear masks while attending class. He announced that he will dock the pay of any school superintendents who issue a mask requirement even though vaccines have not yet been approved for children under 12. Several large Florida school districts decided to require masks despite the governor's threat. Texas Governor Greg Abbott has taken a similar path and banned masks in schools in his state. The largest districts in Texas have also decided to require masks in their schools.

Last century, the comedic duo of Abbott & Costello was frightfully funny; today, the gubernatorial duo of Abbott & DeSantis is just frightening.

No country got it 100% right 100% of the time, but within the OECD, the four Pacific Rim countries (Australia, Japan, New Zealand and South Korea) did the best job of protecting their residents from the ravages of Covid-19. They have continually ranked in the top five for lowest per capita fatality rates. On June 30, their per capita fatality rates were: New Zealand – 0.5; Australia – 3.6; South Korea – 3.9; Japan – 8.5. However, none of the four countries placed a high priority on vaccinating their population and the Delta variant has been spreading rapidly. Their governments have responded with increased emphasis on vaccinations.

Thanks to Operation Warp Speed, the U.S. led the world in the rapid development of safe, effective vaccines. The U.S. has the best-equipped hospitals and the most thoroughly trained physicians in the world. The CDC's guidelines have been widely used in other nations to minimize the spread of the virus. Research on treatments and medications are proceeding rapidly. Yet with 4% of the world's population, the U.S. has incurred 17.7% of reported cases and 14.3% of reported deaths according to the Johns Hopkins online data tabulation.

In his January 2 Wall Street Journal article, former CDC Director Dr. Thomas Frieden identified the countries that, in his opinion, had done the best job of responding to the pandemic in 2020:

continued on page 18

continued from page 17

- Best at early action: Taiwan
- Best at learning from recent epidemics: Liberia (honorable mention - Rwanda and Senegal)
- Best at crushing the curve: New Zealand
- Best at testing: South Korea
- Best at quarantining: Hong Kong
- Best economic protection: Denmark (honorable mention - India, Australia and the European Union)
- Best at public communication: Finland (honorable mention - Germany and South Africa)
- Best location in the U.S.: American Samoa (0 deaths from Covid-19, same as in 1918-19)

Dr. Frieden noted that many developed countries that did well initially faltered during subsequent surges as their governments and people grew tired of implementing effective strategies. Critical of the U.S. response, he noted that "*Bad politics, quite simply, can trump good public health.*"

How did the U.S. wind up in this sorry situation? It's been thoroughly documented that it resulted from a lack of focused state and national leadership. during 2020. Ignoring science and allowing politics to trump public health has resulted in hundreds of thousands of avoidable American deaths. Like many world leaders, former President Trump failed to take the Covid-19 threat seriously. The U.S. consistently ranked in the bottom quartile of the 37 member nations of the Organization for Economic Co-operation and Development (OECD). France and Germany have managed to avoid the bottom quartile, but the U.K. also ranked there. On December 31, 2020, the U.S. ranked 32nd in the OECD.

Biden Declares War on Covid-19

It was only after President Joe Biden took office and declared war on Covid-19 that the U.S. escaped the OECD's bottom quartile. On the day he took office, Biden's first three Executive Orders required masks on federal property, rejoined the World Health Organization and established a White House Covid-19 response team led by Jeff Zients. The series of Executive Orders and presidential directives issued during his first full day in office signaled a more centralized federal response to the spread of Covid-19, including:

- Ramping up the pace of manufacturing and testing.
- Requiring mask wearing during interstate travel.
- Establishing a Pandemic Testing Board.
- Establishing a health equity task force.
- Publishing guidance for schools and workers.
- Finding more treatments for Covid-19 and future pandemics.

Agencies also were directed to identify areas where the administration could invoke the Defense Production Act to increase manufacturing, such as PPE, swabs, reagents, pipettes and syringes. The orders Biden signed were aimed at jump starting his national Covid-19 strategy to increase vaccinations and testing. They laid the groundwork for reopening schools and businesses, and immediately increased the use of masks.

The strong federal guidance and accelerated vaccination campaign worked. On June 30, America ranked 28th of 37 OECD member nations with a per capita fatality rate of 182.7/100,000, followed by the U.K., Poland, Colombia, Italy, Slovenia, Belgium, the Slovak Republic, the Czech Republic and Hungary last at 310.5/100,000. Had the U.S. merely matched the OECD average for fatality rates, 145,000 more Americans would be alive today. Closer to home, had the U.S. matched Canada's performance (69.6/100,000), 374,000 more Americans would be alive today.

So, where does the U.S. go from here? Following the science and placing public health ahead of politics would be a good start. Unfortunately, that will be a steep hill to climb. On August 3, the Commonwealth Fund released its periodic rankings of health systems in 11 high-income countries (Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland and the U.K.). For the seventh time since the rankings began in 2004, the U.S. ranked last overall. Norway, the Netherlands and Australia ranked best. The US ranked last in access to health care, equity and outcomes despite spending 16.8% of GDP on healthcare compared with a range of 9.1-11.7% of GDP by the other 10 countries (2019 data). The US has the highest infant and maternal mortality rates among the 11 high-income countries, as well as the highest rate of avoidable deaths and lowest life expectancy at age 60.

The United States remains the only one of the high-income countries that does not have universal health insurance coverage.

About the Author

Ed Eichhorn is president of the Medilink Consulting Group LLC and founder of the Healing American Healthcare Coalition. He provides management, marketing, and strategic planning advice for medical product and service companies and medical societies. Ed is the coauthor of the first two books in the Healing American Healthcare series and has written commentary and editorials for US New & World Report, Smerconish.com, HR.com, Law 360, Managed Health Care Executive Magazine, and Garden State Focus Magazine, among others. Ed can be reached at Ed@healingamericanhealthcare.com.

•Focus on Finance•

IRS Keeps Expanding the Reach of the Qualified Small Business Gain Exclusion

Daniel Mayo

By Daniel Mayo, JD, LL

Q. What are the details of the most recent IRS ruling and what does it mean for healthcare providers?

A. On June 25, 2021, the IRS released another favorable private letter ruling under section 1202, one of the most powerful gain exclusion provisions in the Internal Revenue Code. The last favorable ruling was issued a few months ago.

The last ruling addresses what it means to be engaged in an excluded brokerage business (and generally limits the exclusion to pure intermediary-type businesses), and the current ruling addresses what it means to be engaged in an excluded health business. The IRS addressed the meaning of the health business exclusion on two prior occasions:

- PLR 201436001 (Sept. 5, 2014) (pharma company that commercialized experimental drugs is engaged in a QTB and not in "health" business); and
- PLR 201717010 (April 28, 2017) (developer of tool to provide complete and timely information to healthcare providers is engaged in a QTB and not in "health" business).

In general, section 1202 provides for the full or partial exclusion of capital gain realized on the sale of qualified small business stock (QSBS). If the requirements are met, then taxpayers can exclude from gross income capital gain in an amount equal to the greater of (i) $10 million, or (ii) an annual exclusion of 10 times their basis in the stock sold (for an exclusion amount up to $500 million). Both of these limitations apply on a per-issuer and per-taxpayer basis, and while the rules limit the exclusion to the greater of the two rules, in practice, the $10 million rule is most often the limiting factor in start-up ventures.

In the most recent ruling, PLR 202125004, the taxpayer was in the business of manufacturing healthcare products that were prescribed by third-party healthcare providers. The taxpayer employed specialists to work on the prescriptions to evaluate, measure, design, fabricate, manufacture, adjust, fit, and service the products it manufactures (think prosthetic limb manufacturer, though the exact type of business was not identified). The taxpayer earned its revenue from the sale of these products, which generally consisted of reimbursements from insurance companies, hospital systems, and patients. Its business operations included a corporate office, a fabrication facility, and lab locations.

The IRS ruled that the taxpayer is not engaged in an excluded health business because the taxpayer "provides value to its customers primarily in the form of tangible product[s]." The healthcare providers that prescribe the products were not employed by the taxpayer, and even though the taxpayer directly interacts with patients, "the interaction is incidental in ensuring these individuals receive a [product] as provided by their prescription." The IRS analogized the taxpayer's business to a custom manufacturer rather than one that offers services based on individual expertise.

The IRS also ruled, without explanation, that the taxpayer's business activity did not fall within the exclusion relating to businesses where the principal asset of the trade or business is the reputation or skill of one or more of its employees.

While a private letter ruling can only be relied upon by the taxpayer to whom it was issued, it provides evidence of the IRS's administrative practice and is helpful to taxpayers in assessing their own situations.

About the Author

Daniel Mayo is Principal, National Lead, Federal Tax Policy at Withum. If you have questions relating to this ruling, please reach out to Daniel Mayo at dmayo@withum.com.

Aligning Physician and Hospital Incentives - A Key Strategy to Support Recovery, Reimagination and Transformation Efforts

Jo Surpin

by Jo Surpin

Given the uncertainty hospitals are now facing, this is not a time to stand still. Facing the future requires a strategic approach to the recovery, reimagination and transformation of hospital services. Data will be critical in assessing initiatives and to providing support for the hospital decision process. Equally important is effective physician engagement.

Engaging physicians starts by coordinating efforts with the medical staff and the hospital. But to fully accomplish physician engagement, physician and hospital financial incentives must be aligned. Alignment is a proven strategy to achieve increased physician engagement, but effective implementation is not easily accomplished. Physician and hospital administration are often at odds with each other. Physicians focus primarily on patient care while hospital administration must also consider financial performance. But what if you could leverage those differences and focus on initiatives that can achieve both improved financial and quality performance, i.e., initiatives that affect care redesign and reduce inpatient costs?

New Jersey has been in the forefront of aligning physician and hospital incentives with its gainsharing initiatives (i.e., incentive payments to physicians based on hospital internal cost savings) since the first Medicare Demonstration in 2009. Based on the success of this demonstration, gainsharing is now part of Medicare bundled payment initiatives, CJR and in the Maryland All Payer model. Recognizing the need for collaboration with physicians, Stark regulations were issued that provide greater flexibility in compensating physicians in various collaboration efforts. The work to refine performance based incentives continues with the NJHA Gainsharing Program to Align Physician and Hospital Incentives.

IMPLEMENTING A REALIGNMENT STRATEGY CANNOT WAIT FOR POST COVID-19 - THE TIME IS NOW

Volumes have declined across all services - inpatient admissions, outpatient visits and emergency department visits - compared with pre-COVID-19 levels. This has had a significant financial impact on hospital operating margins - something that has been considered fragile, even before the pandemic. As noted in the ***NJHA CHART Bulletin Series (VOL 18, February 2021)*** "with inpatient admissions accounting for more than half of all patient revenues, even a modest reduction in volume can wreak havoc on hospital budgets."

Looking at third quarter data from 2020, the CHART Bulletin shows "the pandemic's deep, sustained impact on hospitals when compared to the same time frame in 2019, before COVID-19 sparked the greatest public health threat in a century. The data reveals:

- Hospital emergency department cases plummeted 27 percent.
- Outpatient visits dropped by 20 percent.
- Inpatient admissions decreased 9.6 percent.

- Total expenses jumped 10 percent.
- Patient revenues and average operating margins declined.
- The percent of hospitals posting operating losses nearly doubled."

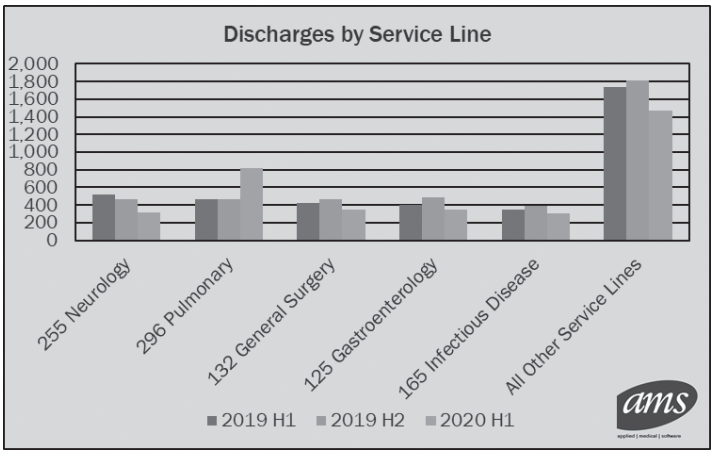
The numbers show that COVID-19 is exerting a considerable toll on hospitals. Perhaps more troubling, is that the impact on hospital financial performance is likely to be significant and, in some cases, permanent. Hospitals cannot delay a post COVID-19 strategy; the time to look forward is now.

MAINTAINING VIABILITY IN A CHANGING ENVIRONMENT - WHAT SHOULD BE CONSIDERED?

Hospitals have always been dynamic but changes that result in improved performance do not happen easily. The role of the physicians and their relationship to the hospital is a major factor to a successful strategy. Flexible strategies need to be developed that can be modified as circumstances change, and updated information becomes available. Continuous review and assessment will be critical.

To evaluate this we must go back to basics. It starts with analyzing the needs of your service area and the changes in demographics. It will also be important to review historical and current data to understand changes in service lines and case mix. Particularly considering the experience with COVID-19 it will be important to account for severity of illness. Figure 1 shows an example of changes in volume by service line.

FIGURE 1 - Discharges by Service Line:



This presents an opportunity to look at what is working and what isn't: What changes occurred due to COVID-19? What services will revert back to pre-pandemic levels, and which may not? What services should the hospital continue, grow, or scale back? For example, Figure 2 shows service line volume for 2019 H2 (July - December) while Figure 3 shows service line volume for 2020 H1 (January - June). The early effects of COVID-19 are seen in the rise in the Pulmonary Service Line.

FIGURE 2 - Discharges by Service Line - 2019 H2:

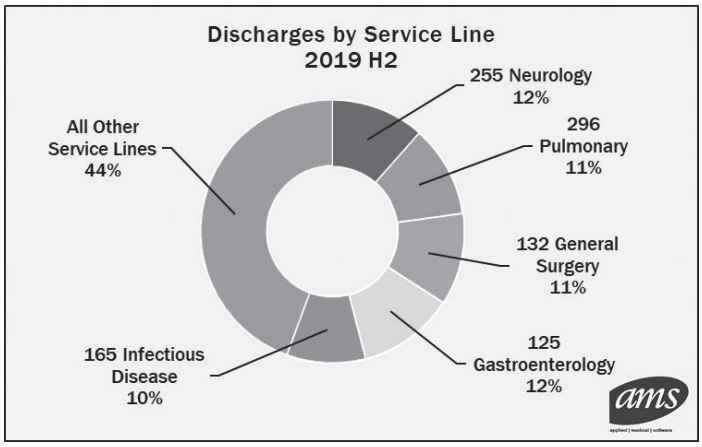
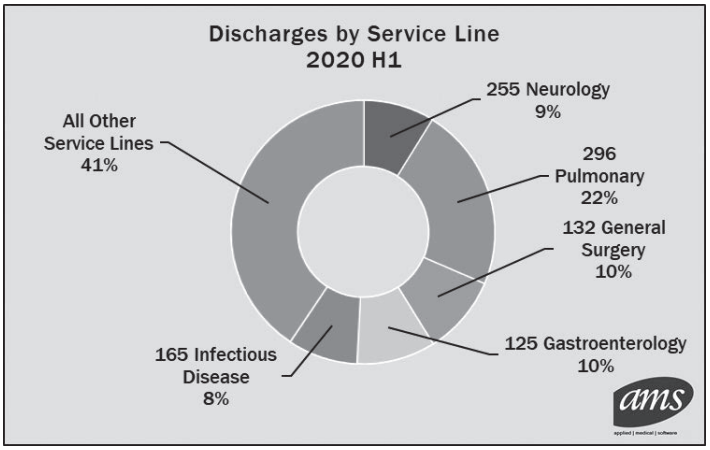


FIGURE 3 - Discharges by Service Line - 2020 H1:



In addition to the service line analysis that focuses on volume changes, it will be important to identify service line opportunities - particularly cost reduction opportunities. It can be assumed that utilization patterns will have changed dramatically, but understanding the detail about these changes will be required in order to develop effective strategies. Figures 4 and 5 show an example of cost reduction opportunities by service line using the NJHA Gainsharing Program "best practice norms" (BPNs). The norms are based on state-wide discharge data for all inpatients. BPNs are established at the 25th percentile (lowest costs) for each specific APR DRG to account for case mix and severity. (APR DRGs are a product of 3M Health Information Systems.) The marginal cost reduction opportunity is 50% of the difference between actual cost and BPN.

Once the opportunities for cost reductions are identified, it is important to look at physician utilization - volume, cost and opportunities for improvement. Figure 6 shows variation in cost by service line. This shows that there are differences in physician practice patterns - differences which could provide opportunities for cost reductions as well as care re-design initiatives.

continued on page 22

continued from page 21

FIGURE 4 - Cost Reduction Opportunities by Service Line - 2019 H2:

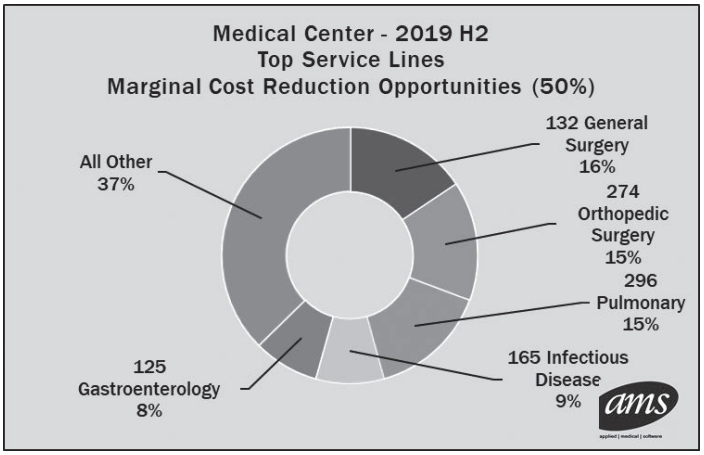


FIGURE 5 - Cost Reduction Opportunities by Service Line - 2020 H1:

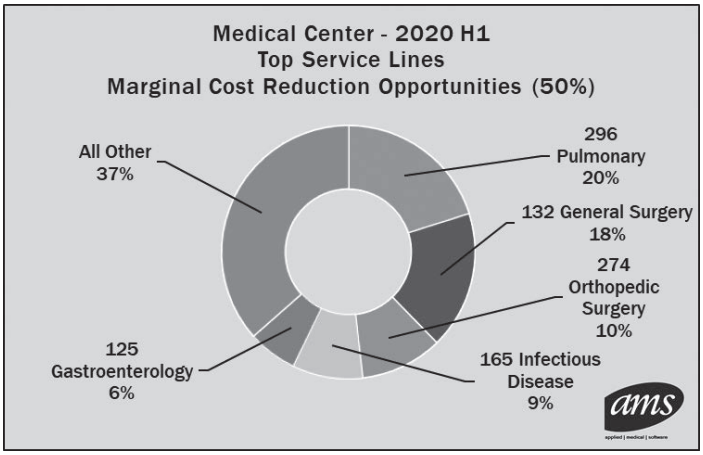


FIGURE 6 - Variation in Cost by Service Line:

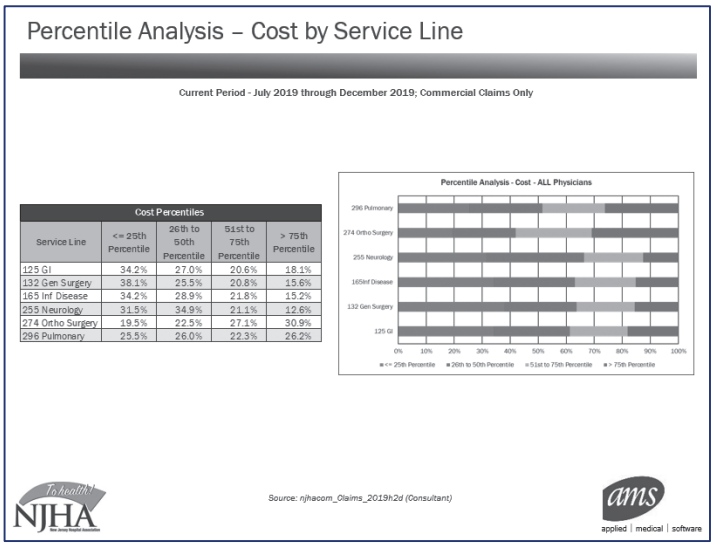
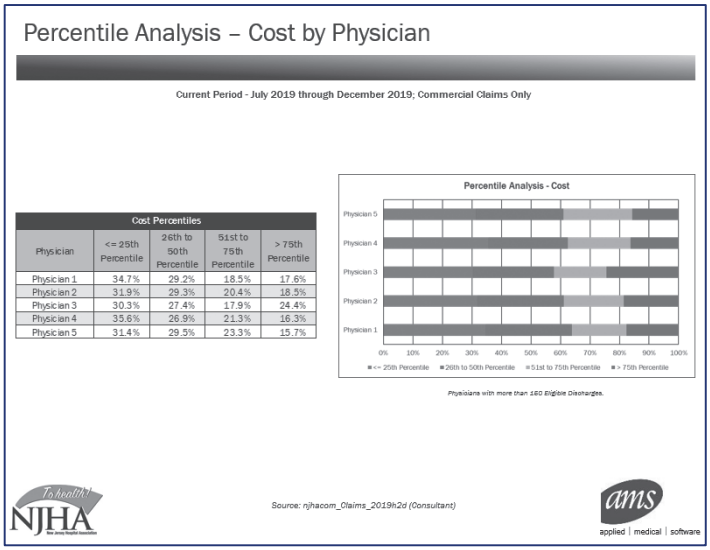


Figure 7 shows the variation in cost by physician. This will help to identify physicians that perform well. In particular, these data can provide a good set of benchmarks for encouraging other physicians treating similar cases to improve their performance. It will also help to determine whether or not you have the right mix of physicians to meet future needs.

FIGURE 7 - Variation in Cost by Physician:



ALIGNING PHYSICIAN AND HOSPITAL INCENTIVES - IMPROVING QUALITY AND FINANCIAL PERFORMANCE

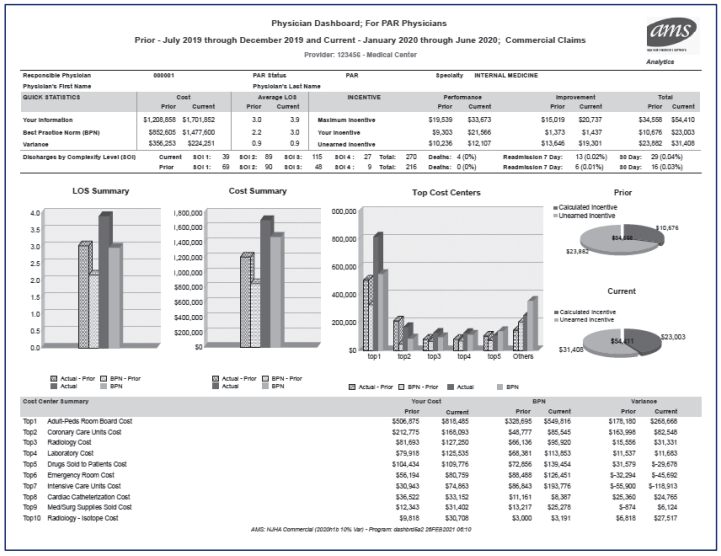
Aligning physicians and hospitals through a gainsharing approach is particularly appealing now as physicians are also facing economic and clinical challenges. Gainsharing addresses operational inconsistencies and complexities. Once costs and clinical standards are established, incentives encourage partners to work together to meet common goals.

To incent physicians to improve their historical financial performance and to reach the BPN, the NJHA Gainsharing Program calculates incentives based on two factors:

1. Performance - actual cost compared to the BPN.
2. Improvement - actual cost compared to each physician's historical costs.

Physician dashboard reports are provided to show each physician their costs, improvement opportunities, calculated incentives, and the incentive opportunity if financial performance improves. (See Figure 8.) But meeting individually with physicians to review results is critical to driving change.

FIGURE 8 - Physician Incentive Dashboard:



The NJHA Gainsharing Program is designed to meet the state legal and regulatory requirements. As such, an oversight or Steering Committee that consists of at least 50% physicians is required. The committee ensures the fair administration of program requirements, prioritizes institutional initiatives, and sets conditions for incentive payment regarding quality and performance issues specific to the institution. The Steering Committee has proven integral to the success of the Gainsharing Program and, given the current environment, should prove to be the perfect forum to discuss, identify and organize the changes needed to go forward.

CONCLUSION

Gainsharing has evolved from a standalone initiative to engage physicians and align hospital and physician incentives, into a program that can be integrated with other initiatives. This widens the focus to the total care provided to patients. The element of success common to any of these initiatives is physician engagement. Financial incentives to physicians provide this key ingredient. Given the uncertainty in the current healthcare environment, leveraging all the tools available will be critical to recovery, reimagination and transformation.

About the Author

Jo Surpin is President of Applied Medical Software, Inc., Collingswood, NJ. She oversees the NJ Gainsharing Program in partnership with NJHA, as well as other Gainsharing Programs offered by state/metropolitan hospital associations in FL, NY, PA and the All-Payer Program in MD. She can be reached at jsurpin@appliedmedicalsoftware.com.

•Certification Corner•

Certified Yet???

Interested in improving organization performance and job fulfillment, standing out among your peers and increasing earning potential? Have you considered getting certified? HFMA offers several certification options:

- Certified Financial Professional (CHFP)
- Certified Revenue Cycle Representative (CRCR)
- Certified Specialist, Accounting and Finance (CSAF)
- Certified Specialist Business Intelligence (CSBI)
- Certified Specialist Managed Care (CSMC)
- Certified Specialist Physician Practice Management (CSPPM)
- Fellow of HFMA (FHFMA)

All certification fees and study materials are included in your membership dues – that's whether you earn one or all of our designations.

HFMA members who have earned either the Certified Healthcare Financial Professional (CHFP) or Fellow of HFMA (FHFMA) designation must maintain their certification every three years. In addition to remaining active HFMA members in good standing, candidates must complete 60 hours of eligible education activities.

HFMA CRCR and CS certificants must maintain their certification every two years. To re-certify as a CRCR or CS, candidate must take a 50-question online exam. Current elearning course is available to help prepare for the exam. With all-access membership there is no cost for the CS and CRCR recertification exams!

Need more information to determine which certification is the right path for you, your team, or your entire organization? Don't wait! Contact Amina Razanica, MBA, CHFP at arazanica@njha.com or careerservices@hfma.org.

Keep your Eye on the Ball – Fee Schedules are Missing the Mark

Ronald Hirsch

by Ronald Hirsch, MD, FACP, CHCQM, CHRI

When the Centers for Medicare & Medicaid Services (CMS) finalized the 2021 Outpatient Prospective Payment System Final Rule, they included their plan to abolish the inpatient only list over the next four years, starting this year with the removal of all orthopedic procedures and most spine procedures. This shift of common procedures off the inpatient only list began in 2018 when CMS removed total knee arthroplasty from the list, creating quite a bit of confusion amongst orthopedists and hospital utilization review staff.

Despite some of the early commentary, the issue with the shift of surgeries from inpatient to outpatient has nothing to do with patient safety. The surgery performed as outpatient at the hospital uses the same operating room, the same nurses, the same implants and has the same recovery as the surgery performed as inpatient. The only difference is in reimbursement. For Medicare patients, the hospital's facility payment will be based on the outpatient Comprehensive Ambulatory Payment Classification (C-APC) instead of the Medicare Severity Diagnosis Related Grouping (MS-DRG). The payment differential can vary. The C-APC is only adjusted for the hospital's wage index, whereas the MS-DRG payment includes indirect medical education (IME) funds, disproportionate share payment, payment for uncompensated care, and more. If the patient or surgery is part of a bundled payment program, such as Bundled Payment for Care Improvement (BPCI), their status as outpatient may make them ineligible for participation in the program, with loss of ability to share in the accrued savings.

Despite some of the early commentary, the issue with the shift of surgeries from inpatient to outpatient has nothing to do with patient safety.

The surgery weighting also varies between inpatient and outpatient. While CMS tries to assign surgeries to the most appropriate C-APC when they remove it from the inpatient only list, until they receive cost reporting from hospitals, they are merely making an educated guess. For joint arthroplasties, the base C-APC and MS-DRG weights are similar but once the additions to the MS-DRG are made, the difference can be over $10,000 per case in large academic medical centers. For some spine surgeries, the weights are considerably different and the base payment rate for many common outpatient spine surgeries is over $10,000 less than inpatient so the differential is worsened once the IME, DSH and other additions are made.

While payments for Medicare beneficiaries are set by CMS and not negotiable, the same cannot be said for almost any other payer, including Medicare Advantage plans and commercial payers. For all of these, the payment rates are set by contract negotiations between the payer and the provider. And as surgeries are shifting from the inpatient setting to outpatient, those contract negotiations become even more important.

Medicare Advantage and commercial payers are not obligated to follow the CMS inpatient only list and in fact can allow surgeries on the inpatient only list to be done as outpatient at the hospital and at ambulatory surgery centers. Some will only allow surgery at the hospital if the patient is complex and at high risk. Some payers will use inpatient only lists developed by commercial entities and others will develop internal lists. As a result of this, along with the increasing difficulty in getting medical patients approved for inpatient admission, it is no longer sufficient to focus contract negotiations on inpatient rates.

Every day in every hospital around the country, utilization review staff struggle getting the appropriate status determination for patients. For scheduled surgeries, the task should be

relatively simple. In the perfect world, clinical information is conveyed to the payer, the payer reviews that information, determines if medical necessity is met, then provides the surgeon authorization to proceed with the surgery and provides the hospital the approved status for the patient once hospitalized. But rarely is it that easy. While Medicare allows physicians to consider the patient's comorbidities and the complexity of the surgery in their designation of status, most payers do not and rely strictly on the expected length of the hospital stay. But even then, many payers refuse to acknowledge that some patients may require a longer stay than the average patient or to approve inpatient admission when the patient develops a complication or delayed recovery that will extend their hospital stay.

As noted above, there is no clinical difference between a surgery performed as inpatient or outpatient. And only Medicare fee-for-service patients require a 3-day inpatient stay to qualify for admission for a covered skilled nursing facility stay. That means much of the time and effort and aggravation trying to get inpatient admission approved is done with the goal of getting the inpatient payment. Yet if you ask any utilization review staff person what the payment differential between inpatient and outpatient actually is, every one of them will tell you they do not know but assume inpatient admission pays more.

Every day in every hospital around the country, utilization review staff struggle getting the appropriate status determination for patients.

It is fair to ask if there should be a payment differential between an inpatient and an outpatient if the same surgery is being performed by the same surgeon. Medicare acknowledges that patients who are admitted as inpatient are those whose length of stay is expected to be longer or whose surgery or peri-operative care will be more complex as clearly such patients will incur higher costs and reimbursement should be higher, although they provide no explanation as to why IME is only attached to inpatient admissions since trainees also participate in the care of outpatients. Commercial insurers on the other hand generally feel the outpatient payment is adequate even for the more complex or longer length of stay patient, perhaps because they feel the majority of costs are from the time spent in the operating room and recovery room and that the extra nursing care for a more complex patient or an extra day in a hospital bed cost relatively little, even if the cost reports do not support this.

To address this dilemma, the first step for finance professionals is to take a deep dive into your most common procedures to find out what you are actually being paid. If you have a great inpatient rate for a common surgery but the payer is always authorizing outpatient, that inpatient rate does no good. If your outpatient rate is comparable to, or even higher than, the inpatient rate, then inform your utilization review staff so they know to accept outpatient status. No sense fighting for inpatient if it will result in a lower payment. But if the outpatient rate is inadequate, it is time to talk to the payer. Likewise, parameters should be developed around the patient who requires additional time in the hospital. Those extra days add up and if the patient is continuing to require hospital care beyond the expected recovery, as opposed to a prolonged stay for convenience, the hospital should be paid more, be it allowing a change to inpatient status or an extra per diem payment in addition to the outpatient surgery payment.

Utilization review staff cannot get water out of a rock no matter how hard they squeeze. If a payer will never authorize inpatient admission, they cannot influence the payment, but finance can. Invite them to your contract negotiations. Ask them for data. Together this shift of surgeries from inpatient to outpatient can be navigated with success.

About the Author

Dr. Ronald Hirsch is a Vice President of the Regulations and Education Group at R1 RCM. Dr. Hirsch is certified in Health Care Quality and Management by the American Board of Quality Assurance and Utilization Review Physicians, is a member of the American Case Management Association, on the Advisory Board of the American College of Physician Advisors, a Fellow of the American College of Physicians, and on the advisory board of the National Association of Healthcare Revenue Integrity. He is the co-author of ***The Hospital Guide to Contemporary Utilization Review****.*

Trends in Fraud and Abuse Investigations since COVID

Jack Wenik

by Jack Wenik

For healthcare providers such as hospitals, physician groups, nursing homes, etc. and the executives and employees who run them, we are at a unique moment in history. The, hopefully, tail-end of the pandemic related to COVID-19 has coincided with a change in administration via the election of President Biden. These two momentous events have had an enormous effect on fraud and abuse enforcement at both the state and federal levels. Some of these changes in direction and emphasis are readily apparent while others are only starting to emerge.

In this article, I identify and describe a handful of trends in fraud and abuse enforcement and provide some practical insights as to what these changes mean for the healthcare industry. This article does not cover fraud investigations emanating from the enormous relief funds enacted to protect the healthcare system and the economy at large from the economic dislocation caused by COVID-19. To be sure, the CARES Act signed on March 27, 2020 included billions of dollars for such measures as the Provider Relief Fund to assist healthcare providers from lost revenues attributable to COVID-19 as well as billions more in the Paycheck Protection Program to provide relief to businesses and their employees more generally. There can be little doubt that many abused these programs and investigations and prosecutions will surely follow. However, this is to be expected with any large-scale relief program. What is more intriguing, and the focus of this article, is how COVID-19 and the change in administrations has altered the landscape of fraud and abuse investigations more generally.

A Shift Away from Beneficiaries

Prior to COVID-19 and the election of President Biden, there was a large scale movement to impose work requirements on Medicaid beneficiaries. CMS issued guidance soliciting proposals for "Work for Medicaid" pilot programs on January 11, 2018. On February 1, 2018, CMS approved Indiana's detailed Work for Medicaid program[1]. A growing list of states soon followed with similar programs receiving CMS approval. Litigation challenging the implementation of these programs ensued and in July 2020, the Department of Health and Human Services sought the Supreme Court's ruling on the matter.[2]

The common theme of these Work for Medicaid programs was that in order to receive Medicaid benefits, beneficiaries had to either work or participate in "community engagement activities." Community engagement activities could include a range of options such as: skills training, education, job search, caregiving, volunteer service or substance disorder treatment. There would be exemptions from these requirements for various categories of beneficiaries including, for example, pregnant women and "medically frail" individuals.

On one level the resistance to Work for Medicaid was surprising. Work requirements for the receipt of benefits by indigent individuals had been established as part of welfare reform during the Clinton era. Indeed, the Work for Medicaid requirements were modeled after those which have been required for years to receive benefits under the Supplemental Nutrition Assistance Program ("SNAP").[3] The legal challenges to Work for Medicaid seemed likely to fail. Many legal practitioners, the undersigned included, expected a wave of enforcement activity targeting fictitious or fraudulent "community engagement activities" and fraudulently obtained exemptions such as doctors falsely certifying that beneficiaries were "medically frail."

COVID-19 and Joe Biden's election to President changed all of this. First and foremost, the health emergency created by COVID stopped any momentum by regulatory authorities to scrutinize Medicaid rolls and/or the legitimacy of beneficiaries. Indeed, as part of the response to the pandemic, application processes were streamlined and it became easier for providers and beneficiaries alike to become part of the Medicaid program. Prosecutions of beneficiaries for fraudulently obtaining Medicaid benefits have been few and far between during the pandemic, and this trend will most likely continue for some time.

Second, as part of President Biden's progressive agenda, the federal government has made an about face on Work for Medicaid requirements. CMS has begun withdrawing the approvals it granted to the pilot programs established by a growing number of states.[4] In February 2021, the Solicitor General acted to remove the issue from the Supreme Court's docket.[5] Thus, while many states are still in favor of imposing a Work for Medicaid requirement, the actions of the Biden Administration have effectively killed this idea for the time being.

Given that COVID is still with us and the current political environment is leaning progressive, except in the most egregious circumstances, we can expect few fraud and abuse investigations of Medicaid beneficiaries. That being said, it cannot go unnoticed that the expenditures associated with coping with COVID-19 have been enormous at both the state and federal level. When you couple this fact with the reality that 39 states have opted for Medicaid Expansion, bringing millions of able-bodied, childless, working age individuals into the program, it becomes apparent that budgetary constraints will, at some point, cause enormous challenges to maintain the current levels of Medicaid expenditures. For example, Medicaid spending in New York alone is expected to reach $80.3 billion in fiscal 2021 with the state's contribution amounting to $24.9 billion despite massive federal COVID-19 relief.[6] At some point, regulators will have to turn their attention to the sheer size of Medicaid rolls.

Expect Substantial Fraud and Abuse Focus on Telehealth

The Department of Justice's ("DOJ") annual healthcare fraud "takedowns" have become an expected ritual viewed by lawyers and consultants who practice in the fraud and abuse area. Calendar year 2020 was no different with DOJ touting its largest takedown ever. Of particular note was the DOJ's assertion that $4.5 billion of the alleged $6 billion in fraud accounted for by the 2020 takedown was related to "telemedicine."[7]

The fraud at issue here is what I call "traditional" telehealth fraud. While they vary in size and detail, the general modus operandi of these schemes is the use of corrupt physicians by fraudulent telehealth companies. The telehealth companies pay rogue doctors to issue orders, prescriptions or certifications for unnecessary medical treatment provided to Medicaid or Medicare beneficiaries, who have been identified by call centers or misleading advertising. Typically, the doctors have no actual doctor-patient relationship with the beneficiaries and, indeed, may never even have met them.

Medicare/Medicaid is charged for prescription medications, durable medical equipment or laboratory testing that is of no real benefit. In recent months, expensive genetic testing for Medicare beneficiaries has been a focus of DOJ enforcement. In many instances the Medicare beneficiary is not even aware of the services that have been submitted for reimbursement in his/her name.

To be sure, given the lucrative nature of fraudulent Medicare/Medicaid reimbursements on a large scale, state and federal authorities will continue to pursue this sort of "traditional" telehealth fraud and abuse. The fact that so many individuals were home bound during COVID-19 means that the sheer volume of this sort of fraud has increased as more individuals provided their Medicare information in response to telemarketing calls, misleading television advertisements and direct mail solicitations. We can expected an elevated level of prosecutions for this type of fraud for many months to come.

What's most intriguing in the telehealth area is the prediction of a "new" type of telehealth fraud by many practitioners, the undersigned included, in the telehealth field. This new genre of fraud is expected to bring increased scrutiny by regulators/prosecutors and more civil and criminal cases.

Prior to COVID-19 CMS imposed onerous requirements/limitations on the reimbursement under Medicare for telehealth services. In order to cope with the pandemic, CMS dramatically eased these restrictions allowing a wide array of medical services to be provided remotely. This included not just telehealth visits/consultations but also "Virtual Check-ins," "E-visits," and "Audio-only" consultations.[8]

The same trend happened at the state level. For example, in New Jersey, regulators authorized a wide range of healthcare services to be provided via telehealth.[9] Healthcare professionals and Medicare/Medicaid beneficiaries embraced telehealth during COVID-19. In 2020, telehealth's share of Primary Care Visits for Medicare beneficiaries went from 0.19% to 43.5% of such visits.[10] Finally, it seems very likely that this dramatic expansion of the use and reimbursement of telehealth will become a permanent part of the healthcare landscape.[11]

With telehealth as an accepted part of federal healthcare programs it seems inevitable that there will be those who abuse it and/or commit outright fraud. Rather than the "traditional" telehealth fraud of shady telehealth companies recruiting unsuspecting beneficiaries to obtain unnecessary healthcare services, the "new" telehealth fraud will involve the same types of fraud and abuse seen in the context of regular, in-person provision of services. All of the potential problems that arise from billing for in-person visits/consultations: up-coding, phantom services, unnecessary services, deficient documentation, etc. will apply with equal vigor to telehealth. Indeed, the lack of an office setting probably increases the opportunities for fraud and abuse and makes it harder to detect same. For example, time based billing codes in behavioral health would be especially subject to fraud and abuse in the telehealth context.

We should thus expect increased audits/scrutiny of telehealth services for the foreseeable future.[12] Criminal prosecutions will surely follow as investigations play out. One recent DOJ prosecution, *United States v. Michael Stein, et. al,* 21 CR 20321 (S.D. Fl), is notable for being the first to include allegations of improper telehealth billing in addition to fraudulent genetic testing. No doubt, free-standing telehealth prosecutions are in the pipeline.

These developments mean healthcare providers should exercise the same care as when they bill for in-person services: document thoroughly, beware of "impossible days" of too many telehealth visits, scrutinize outliers/high volume billers, educate staff as to proper codes/modifiers to be used with telehealth claims, and maintain distinctions between new vs. established patients.

continued on page 28

continued from page 27

COVID-19 Fraud Investigations/Prosecutions Will Continue

With a general five year statute of limitations for criminal prosecutions and a six year statute of limitations for False Claims Act suits, we can expect COVID-19 related fraud and abuse actions to continue for some time. There has been a rash of prosecutions and actions by other federal agencies, such as the Federal Trade Commission, ("FTC") against a host of individuals/companies peddling fake COVID cures and treatments. In a related context, there have also been securities related fraud cases tied to bogus COVID technologies.

For healthcare providers, the COVID-19 fraud and abuse that appears most widespread is the bundling of COVID-19 testing with other, often unnecessary testing, to increase Medicare reimbursement rates. In this sense the fraud and abuse here is much the same as we have seen in the past for drug abuse testing, genetic testing and blood panels that include an appropriate test with a slew of more expensive, unnecessary ones.

One interesting matter is a criminal complaint filed in the Northern District of California, *United States v. Juli Mazi,* (N.D.Ca. July 13, 2021), in which a Naturopathic doctor is accused of providing COVID-19 vaccination cards to individuals who never received the vaccination. It was probably inevitable, given the growing necessity to have proof of vaccination for travel, continued employment, and to attend sporting and other events, that vaccination cards would become a thing of value attracting fraudulent conduct.

Healthcare providers should scrutinize carefully orders for COVID testing that are part of a wider order for expensive testing. Vaccination cards should be treated as a valuable record that needs to be safeguarded. Accordingly, healthcare providers should: track inventory of vaccination cards, establish procedures for issuing/monitoring replacement cards, limit access to blank cards, and establish procedures for who can fill out and distribute cards.

Expect Increased Antitrust Enforcement Activity in Healthcare

During the height of the pandemic with lock-downs and fear, many individuals postponed all but emergency health care. This jeopardized the financial stability of many healthcare providers to the point where federal relief funds were required by many. While antitrust enforcement activity did not cease entirely during COVID-19, there was a precipitous decline as regulators were more concerned with the financial survival of healthcare practitioners and organizations.

In this regard, dramatic change is on the horizon. On July 9, 2021, President Biden issued his "Executive Order on Promoting Competition in the American Economy." The Order singled out healthcare, contending that Americans paid far more for healthcare than residents of other countries and that hospital consolidation left communities with inadequate healthcare options. The President urged DOJ, the FTC and other agencies to vigorously enforce antitrust laws.

That the President means business has been accentuated by his new FTC Chair, Lina Khan. Ms. Khan has already taken actions to increase the Agency's powers and authority. She has written in the past on the need to increase antitrust enforcement and has commented on the need for increased scrutiny of the healthcare industry.

With the financial burdens of COVID-19 lessening we can expect increased antitrust scrutiny of hospital mergers, physician practice acquisitions and private equity investment in healthcare. Attorney General Merrick B. Garland stated that healthcare was a key sector for antitrust enforcement and specifically noted the need to promote competition via telehealth.[13] There can be little doubt that criminal antitrust charges will also be brought as needed against those who subvert competition for healthcare services.

Conclusion

If for no other reason than that healthcare fraud and abuse enforcement generates substantial revenues for federal and state governments in the form of fines, penalties and forfeitures, healthcare providers can expect a continued high level of enforcement activity. As the country emerges from COVID-19 greater scrutiny will be applied to innovations such as telehealth as well as the provision of treatment in response to COVID. Now is the time to dedicate more resources to compliance and risk management and for healthcare providers to be ever vigilant that their practices comport with the law and applicable regulations.

About the Author

Jack Wenik is a Member of Epstein, Becker & Green, P.C. Jack can be reached at jwenik@ebglaw.com

Footnotes

[1] *See* CMS Approval of Healthy Indiana Plan, Expenditure Authority No. 11-W-00296/5, February 1, 2018.

[2] *See* HHS Petition for Writ of Certiorari in *Azar v. Gresham, et al.* No. 20-37, July 2020.

[3] *See, e.g.,* New York Office of Temporary and Disability Assistance Fact Sheet for SNAP Work Requirements, Pub-5105 (Rev. 02/21) (setting forth work requirements and exemption categories similar to those in states' Work for Medicaid pilot programs).

[4] *See, e.g.,* March 17, 2021 CMS letter to Dawn Stehle of Arkansas Department of Human Services.

[5] *See* February 2021 Motion of Solicitor General in *Cochran v. Gresham,* No. 20-37.

continued on page 29

If you Give Joe a Job...

Sandra Lane

by Sandra Lane

When I think about procrastination, I'm reminded of a sweet children's book called "If you Give a Pig a Pancake".

The little pig begins her day with breakfast and becomes distracted with various jaunts from playing dress up to writing post cards.

Despite our best intentions, we may succumb to similar attention shifts.

See if you can relate to my modern-day version of this story.

If you give Joe a job...he'll want a cup of coffee before he begins.

The coffee aroma will remind him of that bucket list trip to Jamaica.

When Joe returns to his desk he spends the next 15 minutes searching the internet for airline ticket prices.

Then he hears a ping from his phone-he has several new notifications on his Sports app.

Joe scrolls through the scores and headlines for the next 15 minutes until he hears another ping; an email has landed in his inbox!

Joe opens his email and begins typing a reply when he remembers he wanted to ask a co-worker to have lunch today.

Joe steps out of the office and is mesmerized by the smell of fresh bagels.

He remembers his last meal was yesterday's dinner and suddenly is hungry.

Joe heads to the break room and begins making a bagel and cream cheese sandwich and realizes he needs a cup of coffee to go with it.

An around we go again...

We have all been in Joe's shoes at some point. We use rationalization and diversion to justify our reasoning to do anything else but the task which currently demands our attention.

Overcoming procrastination boils down to understanding it, accepting it and utilizing actionable strategies to outsmart it.

I hope you will join me in the general session at the HFMA 45th Annual Conference where I will be presenting **Stop Procrastinating & Start Producing** on **Friday, October 8, 2021 at 9am.**

Don't procrastinate, register today and I'll see you there!

About the Author

Sandra Lane is a Certified Professional Organizer, Productivity Specialist, author of ***Ask the Organizer*** *and owner of Organization Lane, LLC.*

---

continued from page 28

[6]Bill Hammond, Empire Center, *New York Medicaid Spending is Projected to Jump 6% in Fiscal Year 2021,* August 25, 2020.

[7]DOJ Press Release, September 30, 2020, *National Health Care Fraud and Opioid Takedown Results in Charges Against 345 Defendants Responsible for More than $6 Billion in Alleged Fraud Losses.*

[8]*See* CMS, Medicare Telemedicine Health Care Provider Fact Sheet, March 17, 2020.

[9]*See, e.g.,* NJ DMAHS Newsletter, Volume 30, No. 04, March 2020 (telephonic and in-home services in lieu of Adult Day Care); NJ DMAHS Newsletter, Volume 30, No. 08, April 2020 (permitting teledentistry); NJ DMAHS Newsletter, Volume 30, No. 09, April 2020 (permitting telehealth); NJ DMAHS Newsletter, Volume 30, No. 12, May 2020 (telehealth wellcare for children).

[10]*See,* U.S. Department of Health & Human Services, Assistant Secretary of Planning and Evaluation, Medicare Beneficiary Use of Telehealth Visits: Early Data from the State of the COVID-19 Pandemic (July 28, 2020), https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//198331/hp-issue-brief-medicare-telehealth.pdf

[11]*See,* CMS, Medicare Physician Fee Schedule, July 13, 2021 (approved "temporary" telehealth services extended until December 31, 2023); MedPAC, "Chapter 14: Telehealth in Medicare after the coronavirus public health emergency," Report to the Congress: Medicare Payment Policy, March 2021 (recommending permanent expansion of telehealth)

[12]Compare, HHS-OIG Statement of Principal Deputy Inspector General Grimm on Telehealth, February 26, 2021 (noting value of telehealth but need for OIG oversight and investigation).

[13]DOJ Press Release, July 9, 2021, *Statement of Attorney General Merrick B. Garland on the Justice Department's Implementation of the Executive Order on Promoting Competition in the American Economy.*

The New Health Industry Cybersecurity Practices (HICP) Rule along with Simplifying IT Environments Helps Organizations Reduce Cyber Risk

Gerry Blass

Jason Tahaney

by Gerry Blass and Jason Tahaney

In today's world, it is more imperative than ever before to maintain cybersecurity best practices. According to a July 2021 article published by PBS, ransomware attacks rose by 62% worldwide between 2019 and 2020. Furthermore, the FBI received nearly 2,500 ransomware complaints in 2020, up about 20% from 2019. As hackers continue to plague companies big and small, organization leaders need a standard framework to help navigate these uncertain waters and defend their businesses from possible threats.

Gerry Blass, President and CEO of ComplyAssistant, and Jason Tahaney, Director of Technology at Community Options, know all too well the challenges that CIOs and others in the IT space are facing. Leveraging their combined 40+ years of experience in the field, Blass and Tahaney are joining forces at New Jersey's HFMA 45th Anniversary Annual Institute to share their insights and expertise with leaders in a presentation titled **"The New Health Industry Cybersecurity Practices (HICP) Rule along with Simplifying IT Environments Helps Organizations Reduce Cyber Risk."**

The presentation will center around the new legislation outlined by the Department of Health and Human Services in the HICP rule. This rule, signed into law on January 5th of this year, is intended to provide a common framework for healthcare IT leaders to follow. The rule compiles the five common cybersecurity threats that organizations of all sizes face, as well as ten best practices or controls for mitigating them. The five threats as defined by HHS are:

- Email phishing attacks
- Ransomware attacks
- Loss or theft of equipment or data
- Internal, accidental or intentional data loss
- Attacks against connected medical devices that may affect patient safety

The controls, also known as "Recognized Security Practices" (RSPs), were established in partnership with Task Force 405(d) to combat the threats outlined above. The RSPs refer to standards, guidelines and methodologies developed under the National Institute of Standards and Technology (NIST) that give leaders a cookbook set of controls that are ready made and easy to implement.

According to the new HICP ruling, when it comes to calculating fines, evaluating audits or reviewing proposed mitigation steps, HHS will consider whether covered entities and business associates adequately demonstrated that they had RSPs in place for at least 12 months. Blass and Tahaney will cover these RSPs, such as e-mail protection systems and endpoint protection systems, in great detail throughout the presentation and offer tips for implementation.

The benefits of following the HICP ruling have never been greater because the stakes for non-compliance have never been

continued on page 32

The Untapped Benefits of a Revenue Cycle Vendor Management Office

John Marchisin

by John Marchisin

With the digital transformation of the healthcare industry, new opportunities consistently arise for revenue cycle departments to improve their performance through data driven decision making. Most organizations use analytics tools to improve their internal processes, but few have transformed their management of their 3rd party vendors. The focus of revenue cycle departments thus far has been on cost-*reduction* associated with vendors because they are still measuring their performance on traditional "best try" metrics as opposed to holding vendors accountable for their end results, which could generate a higher revenue. An increase in performance by outsourced vendors such as bad debt collections, appeals management, eligibility verification, outsourced billing and others, along with incremental improvements in KPI performance could yield significantly greater results to the bottom line. So, how do we track this?

AArete recommends the concept of a Revenue Cycle Vendor Management Office, as seen in many other industries, to drive higher levels of accountability and performance from their vendor partners. This office would be a centralized function reporting to the revenue cycle leader that supports operations leads with all aspects of vendor management, including vendor selection, negotiation, performance monitoring, work sourcing, and performance management. Insight to information and new analytics are critical to derive value from the Revenue Cycle Vendor Management Office.

This untapped area of the business structure solves frequent missteps when dealing with vendors. We often see vendor relationships management becoming muddled due to day-to-day demands of the job and other competing priorities. In some instances, contracts are forgotten and end up being automatically renewed. Often, an understanding of how they are truly performing is a mystery. The Revenue Cycle Vendor Management Office can more effectively manage relationships by instituting a vendor lifecycle approach. This approach involves a wide range of steps or activities that fall into three broad phases: pre-contracting, contracting and ongoing relationship management.

- Pre-contracting: the office weighs vendors' capabilities against the company's needs, develops a vendor negotiation strategy, sends out requests for proposals (RFPs) and reviews the completed proposals.
- Contracting: the office narrows down a short list of qualified vendors, conducting fact-based negotiations, performing due diligence through a series of reviews, and ultimately, signing contracts that include a full range of terms to manage performance and protect the business, including outlining key performance indicators (KPIs), contractual risk management and cyber protections, and service level agreements (SLAs).
- Ongoing Relationship Management: this is where the office truly shines. Continuous performance monitoring allows for course correction before a small problem becomes too large to mitigate. Periodic business reviews that include the Revenue Cycle Vendor Management Office, company stakeholders and vendor representation add value by ensuring all parties receive feedback and action items to keep them aligned around the goals for the relationship. The discussions held during these reviews can also open the door to new opportunities for the vendor to add value to the business as the relationship deepens over time.

Performance dashboards and analytics are the key for the RCVMO to be truly effective. Understanding vendor performance in granular levels proactively/in real time will demonstrate where they are outperforming and underperforming. This insight can be used to stratify your accounts by line of business, payer, geography, etc. and source the work to the best performers. This detailed information can also be used to drive performance discussions and even convert the relationship to a higher degree of performance-based.

All of this can only begin with the acknowledgment that the vendor management process is lacking, and that a notable level of spend and your team's efforts are not bringing in the

continued on page 32

continued from page 30

higher, as evidenced, for example, by the recent ransomware attacks on major companies. Leaders will learn that as a result of documenting and demonstrating evidence of compliance for just 12 months, they could receive:

- Mitigated HIPAA fines
- Favorable and early termination of the HIPAA Audit
- Alleviated remedies in a HIPAA resolution agreement with HHS

Whether you're new to the industry or have been in the industry so long that you've lost count of the years, it's important to understand the threats that are prominent today and how to make sure you aren't combatting them in a silo. Join Blass and Tahaney in Atlantic City this October and prepare your organization today!

About the Authors

Gerry Blass formerly served as CISO for Meridian Health in New Jersey and chair of NJ HIMSS, Security and Compliance Committee where he remains an active member. Blass is founder and CEO of ComplyAssistant, a GRC software and service solutions provider to over 100 healthcare organizations, with a focus on cybersecurity and compliance frameworks and regulations. Blass is a regular contributor and author to leading healthcare compliance and health IT publications and has spoken at industry association events with HIMSS, HFMA, AITP, NCHICA, NJPCA, NJAMHAA and HCCA. Gerry can be reached at gerry@complyassistant.com.

Jason Tahaney is the Director of Technology for Community Options Inc. Jason's passion, drive and commitment to all things Information Technology is clearly shown by his 22 years of experience in the IT field. Over the last 22 years Jason has helped architect a number of Information Technology solutions, specifically in the Healthcare IT field that have stood the test of time and that have helped organizations succeed. While Jason is not tracking down the next Technology trend or researching the latest cyber security threat, he enjoys spending time with his family in a small town located in central NJ. Jason can be reached at Jason.Tahaney@comop.org.

---

continued from page 31

anticipated bang for the buck. The people and technology spend for establishing a Revenue Cycle Vendor Management Office is fairly minimal, though a data cube of outbound data sourcing and inbound results that can help feed information to vendor performance dashboards is an absolute must.

As health systems continue to fight declining reimbursement rates it is imperative that every revenue source be pursued. This includes transforming your vendor performance management processes. As a first step, understand who are managing your vendors, the process they use, and how their performance is reported to you. If your conclusion is that there are gaps, then a vendor management office is right for you.

Sources:

Censinet. (2021, February 22). *Ponemon Research Report: Are Risk Assessments Failing to Secure the Third-Party Healthcare Ecosystem?* https://www.censinet.com/ponemon-research-report-vendor-study/

Holmes, M., & Marchisin, J. (2021, February 23). *Establishing Vendor Management Office Delivers Financial and Operational Advantage*. Supply and Demand Chain Executive. https://www.sdcexec.com/sourcing-procurement/article/21295340/aarete-establishing-vendor-management-office-delivers-financial-and-operational-advantage

About the Author

John Marchisin has over 30+ years of cross-industry consulting and operations improvement experience. He continues to provide profit improvement services to a range of companies including healthcare providers, healthcare payers, technology, retail, and other. His work includes strategic profitability improvement, revenue cycle improvements, gross margin improvements, process redesign, and technology implementation services. John has a particular focus on organizational change management supporting his clients in developing strategies for advancing their business to meet new business and regulatory challenges. John can be reached at jmarchisin@aarete.com

Is Your Revenue Cycle and Billing Staff Properly Educated and Equipped to Handle Growing Insurance Denial and Offset Tactics?

Karlene Dittrich

by Karlene Dittrich, CBCS, CPC, CPMA, CECCS

Many hospitals and other healthcare organizations find themselves feeling frustrated and powerless to insurance denial tactics and offset practices that result in negatively impacting revenue expected for services rendered in good faith. Healthcare organizations of all sizes are being inappropriately hit with increasing denial tactics and declining insurance reimbursements as the result of unfair and misleading claims handling processes, despite the medically necessary need and actual benefit coverage for the healthcare services rendered in good faith. Such negative impact on cash flow has resulted in a substantial increase in access-of-care challenges to many rural and urban communities due to the vast number of hospitals and other healthcare organizations being hit with financial challenges. Over the past 15 years many healthcare organizations have had to make difficult decisions including acquisitions, layoffs, bankruptcies and even closings as the result of financial challenges. Facts support that when denials and offsets increase, cash flow decreases placing healthcare organizations of all sizes at financial risk.

As an ERISA/PPACA Complex Claims and National Appeal Specialist, with extensive training in claims handling compliance requirements supported by revenue protective laws and provider rights, I believe many hospitals and other healthcare organizations hit with significant financial challenges, have or had the ability to remain viable and circumvent such risk factors. Consider the number of hospitals in your state alone that have been forced to close over the past 15 years as the result of financial challenges. How has that impacted the consumers in those areas in need of those healthcare services? It is evident that one of the most challenging areas of revenue cycle management, is the back-end area of denial management. It is in this area of denial management that revenue cycle and billing teams are faced with the most frustrations and limitations. They find themselves at the mercy of disingenuous insurance companies as the result of not being adequately educated and equipped to deal with the growing unfair and misleading denials and offsets received. This is an area of denial management where specialized education and valuable resources are required to effectively assess and address those insurance denial tactics and offset practices that fail to align with applicable state and federal laws.

Facts support the industry offers a wide variety of front-end denial management education and resources related to proper coding, billing guidelines, supportive documentation, and the ability to scrub and perfect claims prior to electronic submittal. However though great research, I have found great lack in educational resources available to navigate those complex back-end denial management challenges and required to effectively overturn benefit denials, reverse offsets and circumvent the negative impact of improper or misleading claims handling processes.

From my 40 years of experience in effectively addressing complex treatment authorization and claim denial tactics, I realize the vast need to educate and help equip healthcare organizations and their revenue cycle teams, with relevant state and federal laws that help strengthen the appeal process

continued on page 34

continued from page 33

and combat unfair and deceptive claim denial tactics that negatively impact cash flow, whether contracted or non-contracted.

Properly educated and equipped revenue cycle and billing teams are vital in remaining viable, with a focus on receiving all revenue compliantly "entitled" and necessary to cover costs associated with providing quality healthcare. With a better understanding of ERISA, other relevant laws and applicable provider rights in the handling of claims, revenue cycle and billing teams can take a compliant approach to assess and properly address any misleading claim denial tactics and recoupment practices commonly exercised in the handling of claims, including those benefit determinations that fail to align with applicable state and federal laws (ie ERISA, PPACA, Managed Medicare, etc).

Albert Einstein shared the quote: "Insanity is defined as doing the same thing over and over again and expecting different results." How many healthcare organizations continue doing the same thing daily while continuing to expect a better outcome? This mindset only proves to guide an organization down a destructive path built of faulty denial tactics and offsets. It is time to take a stand and utilize protected rights that have proven to combat many improper insurance claims handling practices and compel claims payments as entitled.

Many hospitals and other healthcare organizations find themselves feeling frustrated and powerless to insurance denial tactics and offset practices that result in negatively impacting revenue expected for services rendered in good faith.

In order to remain viable in this environment, healthcare organizations need to consider educating their revenue cycle and billing teams on how to adequately assess and address claims that are not handled or processed in alignment with applicable state and federal laws. Your organization has the ability to hold insurance companies accountable to pay all benefits compliantly entitled, for medical necessity services rendered in good faith and avoid unnecessary write-offs. For organizations facing staffing shortages or that are not properly equipped to handle the increase of complex denial tactics and offsets, rather than write off expected revenue, it might benefit the organization to consider outsourcing those more challenging claim denials and offsets to companies with expertise in the area of relevant laws, claims handling compliance requirements and other revenue based protected provider rights. It is time to protect insured consumer healthcare options and hold insurance companies accountable to process claims properly based on applicable claims handling compliance requirements.

Is your organization at risk and/or ready to start getting paid appropriately for medically necessary quality healthcare services rendered in good faith?

Is your revenue cycle and billing staff properly equipped to help improve your profitability?

If not, is your organization ready to equip your staff with more knowledge and valuable resources that offer a compliant approach and process improvements utilizing relevant laws and provider rights that will help strengthen your organization's appeal process, overturn challenging claim denials and reverse recoupments?

Healthcare organizations have the ability, to take back control in providing quality healthcare. However, a positive change cannot be built by complaining, only through knowledge and action can positive results occur and help in reaching revenue goals! If as an industry, healthcare providers and organizations of all sizes do not utilize the protected rights available, we will most certainly lose them. Based on the industry's current state, consider any process improvements that your organization can make in the area of backend denial management to effectively continue providing quality healthcare, cover healthcare costs and remain profitable.

About the author

Karlene Dittrich, CBCS, CPC, CMPA, CECCS is the CEO and founder of MedRevenue Solutions LLC a unique healthcare advocate company that embraces a niche market offering Complex Claims Recovery and Advanced ERISA/PPACA Appeal Services, Denial Management Consulting and Training Services. Karlene utilizes her complex denial management training, expertise, auditing certifications and vast industry experience to assist and educate healthcare organizations nationwide, in recognizing and recovering insurance revenue compliantly entitled for services rendered in good faith and not processed in alignment with applicable state and federal laws. She is a frequent and repeat speaker at various HFMA, MGMA, AAHAM, ASC and other healthcare specialty related conferences nationwide, and has authored a variety of claims recovery and denial management related articles. Karlene can be reached at medrevenue@bellsouth.net

Creating Liquidity Through the Sale of Ancillary Business Segments

by Christal Contini, Esq., Richard Cooper, Esq., Christopher Jahnle and Kirk A. Rebane, ASA, CFA

Christal Contini

Richard Cooper

Christopher Jahnle

Kirk A. Rebane

The financial picture for hospitals, especially not-for-profit hospitals, has not been bright for many years. There has been extreme pressure on operating cash flows due to healthcare reform and new industry dynamics, including changes in care management. Payers have begun to treat hospital outreach or outpatient businesses less as an extension of the hospital and more along the lines of their independent market competitors which results in downward pressure on reimbursement. The new price transparency rules brought about by reform and its particular impact on hospitals in ancillary, outpatient, and non-core business areas has been a financial burden on hospitals. Healthcare systems faced ever increasing capital requirements to support investments in information technology (data, connectivity, and security needs), the operating impacts of new hospital/physician paradigm, and facility improvements and expansion of capacity to accommodate new Medicaid and insured volume. These additional costs were being incurred while there were continuous budget cuts from government and third-party payers. The debt markets were becoming increasingly restrictive and expensive. Consequently, many hospitals were operating with negative, or slim, margins. Hospitals were in a never-ending cycle of looking for new sources of revenue and cash.

Then came COVID-19. The virus and its effect on the U.S. have created historic financial pressures for the country's hospitals and health systems. Revenues plummeted due to the lock down and suspension of elective and non-essential procedures; revenues have yet to return to pre-pandemic levels. Simultaneously, costs increased as hospitals dealt with a new type of operating environment. In addition, COVID-19 created substantial job losses, leading to an increase in the number of uninsured patients. The number of patients with employer-sponsored health coverage has declined, with a corresponding offset in the increase in Medicaid patients.

Historically, payment reforms occurred over long periods of time, allowing a healthcare system time to plan and adapt their cost structure and operations. The traditional strategies utilized by hospitals to improve liquidity and generate capital included revenue cycle improvements, operational efficiency efforts, expense reduction programs, and deference of capital expenditures. By the time COVID-19 came about, such strategies had been fully implemented in many cases, and there were no more efficiencies to be squeezed out. In addition, some of the cost cuts made are unsustainable; deferred capital investment in plant and IT would need to be satisfied at some point. COVID-19 exacerbated the need for new strategies.

continued on page 36

continued from page 35

Given the worsening financial situation, hospital systems should now conduct ongoing enterprise-level reviews, and if necessary, reshape their business portfolios. Systems face an allocation process for scarce capital resources, including cash capital, management resources capital, and physical space capital. This allocation process can result in the classification of certain ancillary functions as non-core. As a response to the financial pressures, hospitals can seek to monetize their non-core assets and service lines, their underperforming assets and service lines, and their real property. Turning these ancillary functions into cash can be accomplished through joint ventures, outright sales, outsourcing, and strategic affiliations/management contracts. In conjunction with the monetization process, ongoing clinical costs can be controlled, if not lowered, through carefully arranged provider services agreements with the new partner. Examples of potential non-core service lines are:

- Clinical laboratories
- Imaging centers
- Pharmacy
- Home health agencies
- Hospice services
- Long term care services
- ASCs
- Dialysis centers

A healthcare system needs to assess an ancillary divestiture program while formally reviewing all options within the context of its overall strategic plan. The system must analyze its strategic financial position, and its market and competitive positions, within the context of key market demand and volume trends. The strengths and weaknesses of clinical programs and service lines must be determined, and a system should develop a strategic framework to identify high potential arrangements. First, take an inventory of non-core and/or underperforming assets. The next step would be to determine the strategic implications of disposing of, or entering into a joint venture on, the identified assets and/or service lines. Hospitals need to carefully audit and analyze their current operations in order to identify any compliance, regulatory, or operational issues that would potentially limit the number of interested buyers, lower the purchase price, and delay the deal. For those assets and/or service lines that survive the strategic test and the audit, conduct a preliminary valuation in order to quantify the monetization opportunity.

A healthcare system needs to assess an ancillary divestiture program while formally reviewing all options within the context of its overall strategic plan.

Healthcare systems can realize various benefits of an ancillary divestiture program. First and foremost, such a strategy can generate immediate and substantial cash proceeds for a healthcare system. The system's balance sheet can be improved, which could lead to improved ongoing access to capital. Capital of all forms – financial capital, management capital, facility capital – can be redeployed into more optimal strategic areas. Management can focus on the core assets and services lines of the institution.

If structured appropriately, a health system's ongoing cost for ancillary services can be stabilized, if not reduced, and future capital investment in that ancillary can be avoided. In the hands of a company specializing in that industry, the healthcare system will be assured that the ancillary's offerings will be at the technological cutting edge. Indeed, the clinical offerings of the program, in the hands of an industry expert, could be improved or broadened. The system can avoid the ever-increasing costs of regulatory and compliance requirements. The mantra of healthcare reform has been to provide more care, reduce costs, and improve quality – can such seemingly divergent goals be better achieved by a hospital or by an entity specializing in that particular ancillary? Care must be taken to ensure that current service levels are maintained, if not improved. Finally, and especially for not-for-profit entities, employment can be preserved in the community - often critical to a mission statement.

Once the system has identified the assets/service lines to be fully or partially divested, and prior to going to market, an assessment should be conducted to identify and resolve any regulatory, legal, or business deficiencies. Team members for the process should be identified, including both internal employees and outside financial and legal advisors. A data room should be established. The system should set clear and preferred goals and objectives related to valuation, deal structure, post-transaction operating model, post-transaction costs and service levels, and the timeline – the longer the deal period, the more likely the deal will be diverted. Finally, it is time to identify potential deal partners.

From a healthcare system's perspective, it is important to find the partner/buyer that is best able to meet the organization's strategic needs. The system wants to maximize the value and purchase terms of a transaction, while taking

into account that there exists both economic value and non-economic value. The management services agreement should protect access to care and quality of care by minimizing the risk of clinical and quality degradation post-transaction. Care should be taken to minimize organizational disruption during the sale process. The system and its advisors must structure a process and a transaction that facilitates regulatory approval. And finally, consummate a transaction which leaves a service line consistent with the healthcare system's mission statement and charitable objectives, and which optimizes the solution for all stakeholders:

- The patients
- The healthcare system
- The employees
- The caregivers
- The payors
- The vendors
- The community

From a buyer's/partner's perspective, former hospital assets or service lines can be attractive for several reasons. Compared to a hospital, a third-party specialty operator can often operate businesses more efficiently and profitably, with no decrease in quality. A third-party most likely would have a lower cost structure, primarily due to wages and benefits. In addition, the new partner would have a clinical expertise, and can demonstrate better clinical outcomes at lower costs. A buyer could still potentially benefit from trading on the goodwill and name of the hospital, proactively through co-marketing and co-branding.

In conclusion, as a response to the financial pressures, and within the context of the overall strategic plan and mission statement, healthcare systems should evaluate whether they can monetize their non-core assets and service lines, their underperforming assets and service lines, and their real property, while at the same time stabilizing, if not lowering, their ongoing costs for such services. The ability to refocus the financial capital, management capital, and physical space capital on core operations could serve as the bridge until the next crisis inevitably arises.

About the Authors

Kirk Rebane is Co-Founder and Managing Director of Haverford Healthcare Advisors, a specialized financial consulting firm dedicated to serving the business valuation and transaction advisory needs of enterprises participating in the healthcare services industry with a specific focus on hospital-based specialties, including anesthesiology, radiology and imaging, and pathology and clinical laboratory. He has originated and completed numerous transactions across a variety of healthcare service segments.

Chris Jahnle is Co-Founder and Managing Director of Haverford Healthcare Advisors, a specialized financial consulting firm dedicated to serving the business valuation and transaction advisory needs of enterprises participating in the healthcare services industry with a specific focus on hospital-based specialties, including anesthesiology, radiology and imaging, and pathology and clinical laboratory. He has originated and completed transactions across a variety of healthcare service segments with a combined value of more than $2.5 billion.

Richard Cooper is the Co-Chair of McDonald Hopkins' National Healthcare Practice Group and Co-Chair of its Healthcare Restructuring Practice Group. He focuses his national practice on representing a wide variety of healthcare industry clients in transactional, restructuring, corporate, compliance, regulatory, licensure, reimbursement, contractual, strategic planning, and venture matters.

Christal Contini is the Co-Chair of McDonald Hopkins' Mergers and Acquisitions Practice Group. Her national practice is focused on representing physician practice groups, medical laboratories, behavioral health facilities, search funds and both strategic buyers and sellers in various types of transactions, including complex mergers, acquisitions, dispositions, leveraged buyouts, distressed acquisitions and dispositions, financings, and investments

The Invisible Community and Its Impact on Healthcare

Valerie Sellers

by Valerie Sellers, MHA, CHE

Having spent 17 years working for a large hospital association, I have an appreciation for the challenges that hospitals and all providers continually face when trying to provide quality healthcare to the communities they serve. I am now the CEO of the New Jersey Association of Community Providers (NJACP) that represents sixty-four agencies that provide services to individuals with intellectual and developmental disabilities (IDD).

When I first started in 2013, it struck me that I had no knowledge of a community of providers that serve the most vulnerable in our society. Whether this was simply a lack of exposure or simply ignorance on my part, I have since learned that individuals with IDD are invisible to most of society, including those in the healthcare sector.

Of the more than five million individuals with IDD nationally, seventy-one percent live with a family caregiver, thirteen percent live in a supervised residential setting and sixteen percent live alone or with a roommate. At the national and state level, the numbers continue to grow as more individuals enter the system following high school and as more individuals leave the institution to live in the community. There are 24,000 individuals in the state receiving some level of services. There are a number of services that are offered including residential housing (group homes), day programs, supported employment, pre-vocational training, respite, among many other services.

Of the more than five million individuals with IDD nationally, seventy-one percent live with a family caregiver, thirteen percent live in a supervised residential setting and sixteen percent live alone or with a roommate.

Nationally, approximately $65B in public funds are allocated to people with Disabilities in 2015, including both intellectual and physical disabilities with New Jersey allocating almost $2B to the disabilities community. The majority of funds (56%) are allocated to Home and Community Based Services with the objective that those with disabilities should be afforded the opportunity to live in communities rather than institutionalized as had been the case for decades and continues in many states throughout the country. New Jersey continues to serve approximately 1200 individuals with IDD in Developmental Centers throughout the state.

Many of the providers I represent do not have MBAs; more often they are social workers that are following a life calling, caring for individuals with needs that most of us could not even imagine. These providers often operate on extremely thin margins and any change introduced into the system can have an immediate and devastating impact on their financial viability. Most disturbing is that providers and those they serve are almost invisible within the larger healthcare community and yet those they serve are remarkably high users of healthcare services.

Discrimination toward those with IDD, although sometimes very subtle, exists in all healthcare settings; be it a physician's office or an emergency room. Often clients are asked to wait outside or are told that they simply cannot be provided services due to their behaviors. There's no question that trying to provide care to someone that is deaf and blind and may have intellectual disabilities poses significant challenges as does trying to perform an assessment on an individual that is non-verbal and can't articulate what he/she is feeling. It can be truly traumatic for someone that goes to the hospital emergency room or is hospitalized for care; a daily routine is disrupted creating significant fear and anxiety beyond what we may experience. Effective communication with someone in this state is challenging at best and sometimes impossible. How can hospital staff know that they have to approach someone from the left side rather than the right side to avoid an aggressive reaction? How does a nurse with many other patients calm a patient that is non-verbal and may resort to yelling to express his/her needs? Is a feeding tube the only solution to someone that needs their meals pureed because of issues associated with choking?

Because people with intellectual and developmental disabilities are often shunned by society, healthcare providers need a better understanding of this community, the diversity of challenges they face on a daily basis and there should be collaboration with families and staff from agencies that serve this community every day. By understanding those with IDD, perhaps readmissions, failure to follow discharge instructions, or repeat visits to the emergency room, could be reduced, benefitting providers and those with IDD alike.

About the Author

Valerie Sellers joined the New Jersey Association of Community Providers (NJACP) as its Chief Executive Officer in 2013 after spending 17 years with the New Jersey Hospital Association, of which the last 8 years she served as Senior Vice-President, Health Planning and Research. She is an authority in areas concerning the IDD Adult Community, Managed Care, Emergency Preparedness, Healthcare Access and Disparities, and, Community Health Needs Assessments. She was appointed by NJ Governor Murphy to serve on the Independent Developmental Disability Fee-for-Service Transition Oversight Board, as well as Governor Murphy's Healthcare Transition Team. Ms. Sellers received both her BS in Industrial and Labor Relations, and her Masters of Health Administration Studies, from Cornell University. Val can be reached at vsellers@njacp.org.

Worksheet S-10 Audits: FFY 2018 Insights and Future Preparation Tips

by Michael Newell, Jonathan Mason, & Heather Keser

Michael Newell

Jonathan Mason

Heather Keser

Despite expectations, the federal fiscal year (FFY) 2018 S-10 audit process wasn't complete with all data uploaded to the Hospital Cost Report Information System (HCRIS) by December 31, 2020. At that date, however, the data of 1,540 of approximately 2,400 audited hospitals changed from their as-filed cost reports.

This provides significant information to reassess initial observations of the audits. These S-10 audits are complex and place additional burdens on hospitals to meet the stringent audit requirements.

Below, explore the results of changes visible at the year-end and how they can provide insight for hospitals facing future audits.

Audit Overview

Approximately 2,100 more S-10 Medicare Administrative Contractors (MAC) audits were performed during the 2018 round of audits than in previous cycles.

The FFY 2018 audits included all identified Disproportionate Share Hospital (DSH) qualified hospitals, plus sole community hospitals. It's anticipated that Centers for Medicare & Medicaid Services (CMS) will continue to instruct MACs to complete audits on this large group of hospitals in future years.

As your hospital prepares for future audits, it's worthwhile to step back and assess your policies to verify they're clear, accurately represent the provided discounts, and actively followed.

It appears that a large portion of the audits were complete by December 31, 2020, but not all. With that in mind, any analysis on the Q4 2020 Healthcare Cost Reporting Information System (HCRIS) file should note that not all audit results are present.

Additional information on the following items can be reviewed in our initial November 2020 audit assessment located at https://www.mossadams.com/articles/2020/11/ffy-2018-worksheet-s-10-audit-observations. Items include:

- The 2018 audit letter
- The requested year-over-year documentation requirement
- MACs' in-depth review of hospitals' charity and financial assistance policies
- Additional observations and challenges

New Audit Changes

Steps Taken Before Samples Were Requested

Once the requested information was provided, MACs generally performed several steps before requesting samples, such as:

- Reviewing the financial assistance policies
- Looking for duplicate claims, both within categories of provided data and between the various categories
- Tying out accounts within the provided template

Financial Assistance Policies

Of particular note, MACs spent significant time trying to

understand transactions and transaction codes—and how they relate to charity and financial assistance policies.

As your hospital prepares for future audits, it's worthwhile to step back and assess your policies to verify they're clear, accurately represent the provided discounts, and actively followed.

Duplicate Claims

Hospitals encountered challenges with MACs as they worked through duplicate claims reviews.

Due to the fluid nature of the process across the revenue cycle, patient classifications change; write-offs are often reversed or revised based on new information. Care should be taken before concluding the presence of a patient duplication.

Tying Outpatient Claim Activity and Reconciling Accounts

Tying outpatient claim activity and reconciling accounts was perhaps the biggest challenge—one that will likely remain once new cost reporting requirements are active for periods beginning on or after October 1, 2020. Timing was one of the most prominent issues, among many, that contributed to the challenge. Though providers were afforded additional time compared the initial requests in many cases, the amount of data to compile and additional steps to complete, like reconciliations, required even more.

Due to the fluid nature of the process across the revenue cycle, patient classifications change; write-offs are often reversed or revised based on new information.

Completing the reconciliation of the accounts within the MAC templates proved difficult due to the fluid nature of an account over time—and because activity can cross cost reporting periods.

Steps Taken After Samples Were Requested

The categories sampled or the sample size weren't consistent across MACs. As a result, hospitals had different experiences depending on their MAC.

Documentation Requests

The documentation required for the charity review, however, was somewhat consistent across MACs. These included:

- **Uniform Billing Form 04 (UB-04)**. These verify total charges and the exclusion of professional fees.
- **Charity and financial assistance policies.** These must identify the underlying support required, by policy, to grant the charity award. The hospital must then provide the underlying support once it's identified. This includes items like charity applications, presumptive eligibility score sheets, low-income status determinations, and support.
- **Remittance advices or Explanation of Benefits (EOBs).** These verify that the write-offs reported on line 20, column two were only the patient responsibility amounts.
- **Patient account histories.** These verify the write-off amount.

Documentation proved to be challenging for some hospitals, so it's strongly advised to investigate documentation for future audits as soon as possible.

For example, if your policy calls for 10 items of supporting documentation to reach a specific charity determination, anticipate that all 10 items will be requested. If your policy permits presumptive eligibility scoring, the score sheets are required.

Some significant proposed audit adjustments resulted from lack of supporting documentation issues.

Bad Debt Sample Reviews

Similar documentation was requested in support of the bad debt write-off claimed.

As part of the audit review, MACs identified cases in which:

- The bad debt write-off was more than the deductible, coinsurance, or copayment amount for insured patients
- The self-pay discount wasn't applied before the bad debt amount was determined for accounts where insurance payment was recouped
- The remittance advice or EOB couldn't be produced to verify patient responsibility

Each of these items resulted in audit adjustments, and in some cases, material extrapolations.

Early Insights Based on the Data

To compile an idea of the audit result, we looked at FFY 2018 cost reports in HCRIS and compared the Q2 2020 HCRIS data to the Q4 2020 HCRIS data.

We identified line 30 changes for 1,539 hospitals out of the 2,389 eligible hospitals from the 2021 final Inpatient Prospective Payment System (IPPS) rule. Overall, line 30 dropped over $1 billion dollars, or 4.7%.

Following is a summary of the key components that contributed to that change.

continued on page 42

continued from page 41

Line 20 - Uninsured and Insured Charity Care Charge Changes

On line 20, total charity care charges, 1,393 hospitals experienced a change.

The revised amount for uninsured charity was $207 million greater than initially reported, only a .37% change.

Insured charity experienced a more dramatic change. The revised amount was $1.04 billion less than initially reported, or a 27% drop.

This is significant because insured charity charges aren't subject to the cost-to-charge ratio. Accordingly, the impact on actual uncompensated care cost reimbursement is dollar for dollar.

Given the significant redistributive nature of the pool distribution, hospitals should invest the time and resources necessary to verify CMS uses complete and accurate data.

Line 22 - Patient Payments

For payments reported on line 22, 401 hospitals had updated numbers.

While the amounts were relatively modest compared to total charity dollars, the decrease was dramatic as both payments for uninsured and insured charity dropped over 90%.

Line 26 - Total Bad Debt Expense

With respect to bad debts, 1,415 hospitals experienced a change totaling a negative $2.2 billion dollars, or 7.4%.

While bad debt amounts weren't necessarily a focus item in the earlier audits, all MACs in this round worked on the bad debts claimed by hospitals.

Line 30 - Changes in Total Calculated Uncompensated Care

Overall, 1,050 of the 1,539 hospitals that experienced a change in line 30 saw a decrease in their numbers; 489 saw an increase.

The largest line 30 decrease was $93 million dollars; the largest increase was $47.4 million.

The actual reimbursement impact on these hospitals is significant and given that the distribution of the pool is a zero-sum game, these changes impact all participants.

Other Considerations

Hospitals advocated that CMS audit the data once it signaled data would be used to distribute the uncompensated care pool, projected to be over $8 billion dollars for 2021.

Continued Plans to Audit All Qualified Hospitals

Initially, CMS audited approximately 25% of qualified hospitals.

In this last round of audits, CMS audited the entire group and signaled that it plans to continue auditing all qualified hospitals each year.

Report Filing Instruction Changes[1]

In November 2020, CMS issued a Federal Register notice required under the Paperwork Reduction Act (PRA) of 1995 announcing an opportunity for the public comment to CMS's "intention to collect information from the public."

The information to be collected from this particular notice is associated with the CMS-2552-10 Hospital and Health Care Complex Cost Report and included proposed changes to cost report filing instructions related to data reported on S-10.

Proposed changes include:

- CMS is clarifying the definition of courtesy discounts and what should be excluded from Worksheet S-10.
- "Hospitals that received HRSA-administered Uninsured Provider Relief Fund (PRF) payments….for services provided to uninsured COVID-19 patients, must not include the patient charges for those services."
- The reported cost-to-charge ratio will now be for the general short-term hospital portion only—not the entire hospital complex—effective with cost reporting periods beginning on or after October 1, 2020.
- For cost reporting periods beginning on or after October 1, 2020, hospitals can no longer claim charges for services other than the general short-term acute hospital and now must exclude psychiatric unit, skilled nursing facility (SNF), home health agency (HHA), and end-stage renal disease (ESRD), for example.

For a thorough understanding of what's proposed regarding Work-sheet S-10 instructions, a review of the full Medicare Provider Reimbursement Manual (PRM) issued with the notice is advised. Additionally, as the reporting and auditing of data for Worksheet S-10 has become more complex over time, these new instructions should be read in conjunction with MLN Matters SE17031 as well as CMS Questions and Answers for Worksheet S-10.

Given the significant redistributive nature of the pool distribution, hospitals should invest the time and resources necessary to verify CMS uses complete and accurate data.

Data Templates[2]

Effective with cost reporting periods beginning on or after October 1, 2018, hospitals were required to submit a listing supporting charity care claimed in the cost report. Failure to do so would result in the rejection of the cost report. However, CMS offered no standardized format for submitting the required data. That's being changed as a result of the aforementioned Federal Register notice.

Effective for cost reporting periods beginning on or after October 1, 2020, CMS proposes a new Exhibit 3B, which represents the standard format for reporting charity care amounts claimed in the cost report. The new exhibit, which is found on page 127 of the CMS PRM Chapter 40, has 27 columns and includes data points with revised definitions.

In addition to providing charity care information at the detailed patient level in as-filed cost reports, effective for cost reporting periods beginning on or after October 1, 2020, information regarding non-Medicare bad debts must also be reported at the patient level on Exhibit 3C.

The new exhibit, which is found on page 129 of the CMS PRM Chapter 40, has 17 columns and also includes data points with definitions included in the proposed PRM.

Properly retain and be ready to retrieve necessary data when going through, or planning to go through, patient accounting system conversions.

Steps Hospitals Can Take to Prepare for an Audit

Continually evaluate charity and financial assistance polices to verify they're clear, complete, and cover actual self-pay discounts and charity discounts applied to patients.

To prepare for audits:

- Compile data at the patient level, not the general ledger level
- Verify that supporting documentation used to make charity determinations is received from the patient and maintained on file
- Consider conducting mock audits internally or through an independent resource

Properly retain and be ready to retrieve necessary data when going through, or planning to go through, patient accounting system conversions.

To learn more about how proposed changes will affect your organization and Medicare cost reporting efforts, potential implications of S-10 audits, or for assistance filing amended worksheet S-10 data to stay compliant with cost report instructions, contact your Moss Adams professional.

About the Authors

Michael Newell has worked in healthcare financial management since 1982. He specializes in preparing and reviewing Medicare DSH and Worksheet S-10 for cost report filings. He can be reached at michael.newell@mossadams.com.

Jonathan Mason has worked in health care finance since 2004. He currently focuses on Medicare DSH and Worksheet S-10 engagements for hospital clients ranging from small rural facilities to large corporate hospital systems. He can be reached at jonathan.mason@mossadams.com.

Heather Keser has worked in hospital government reimbursement since 2011. She provides Worksheet S-10 services to hospital clients ranging from small rural facilities to large corporate hospitals systems. She can be reached at heather.kesser@mossadams.com

Footnotes

[1]As of August 10, 2020, these proposed changes are still under consideration by CMS.

[2]As of August 10, 2020, these proposed changes are still under consideration by CMS.

Financial Sustainability

Leveraging data to improve provider profitability: How advanced analytics can help lead to a more financially sustainable future

Michael Duke

David Gregory

Mary Ellen Kasey

by Michael Duke, David Gregory and Mary Ellen Kasey

Facing increased financial pressure, it is ever more important for healthcare organizations to employ strategies that ensure they have the financial resources required to operate and succeed over the long term. Hospitals are challenged to meet their communities' needs in delivering high quality care, controlling costs and ensuring consumer satisfaction, as reimbursement is decreasing. One approach is to evaluate which service lines are essential to the organization's long-term success. Service line analysis and advanced analytics can help hospitals attain a more financially sustainable future, while detailed claim data can be used in a new way to evaluate service line performance.

Integrating detailed inpatient, outpatient and physician-based claim data is at the core of service line profitability analysis. This creates a unique data dynamic that allows for increased sophistication in analysis and visual representation of opportunities. Granular claims data creates an opportunity to link data that would normally be lost at an aggregate level to support rapid improvement opportunities.

Organizations can adjust case-by-case for severity, track provider performance, remove "one-off" anomalies, and capitalize on sophisticated drill-through capabilities and insightful augmented analytic solutions such as Natural Language Generation (NLG) to expedite opportunity identification.

Reimbursement data can be incorporated to facilitate a deeper understanding of performance. Leveraging payer remittance data and linking it to specific claims data can provide a more thorough understanding of service performance. Including current reimbursement levels as well as revenue leakage affecting service line performance (i.e., claims denied for medical necessity, lack of authorization, missing clinical documentation) can provide a measurement of service line performance. Hidden reductions in reimbursement (e.g., DRG downgrades, incorrect transfer DRGs) can be identified with this level of granularity. Current service line analysis techniques rarely achieve this level of specificity.

Using detailed claims data, claims can be linked directly to charges associated with an episode and then tied to the Materials Management Item Master, allowing connection to direct supply costs. Additionally, linking both provider salary requirements and other human resource costs to each episode, organization leadership can understand direct FTE costs associated with each procedure, thereby evaluating performance at an aggregated service line level in order to understand if lower cost resources could be deployed. While indirect costs should be considered at some level, these are typically long-term improvements, whereas adjustments could be made to direct costs in a very short timeframe once issues are identified.

Natural Language Generation (NLG) is a technical solution that can evaluate millions of rows of granular data and deliver contextual information in natural language. This technology can help leadership quickly understand large data sets by explic-

itly defining trends and outliers in plain language without requiring complicated data analysis. Using NLG, insights are presented in a meaningful way that drives improved decision-making.

Techniques and approaches to leverage data

Differing approaches to healthcare analytics have promised a lot over the years, yet have typically failed to deliver. Analytics have improved, but they are not much further along than years ago with key performance indicator spreadsheets and cost accounting approaches. While there is value in both, what is needed to realize true actionable information and improve financial visibility is:

- Data collection
- Data modeling
- Data visualization
- Advanced analytics

To obtain the appropriate level of granularity, data sources should include systems that are internal to the organizations, including:

- 837 claims data
- Standard system reports from the host system (charge detail, etc.)
- Host system master files (CDM, etc.)
- Ancillary system reports / master files (materials management supply master, etc.)
- Payment and adjustment transactional data from host
- 835 data
- System audit logs

Modeling is important as a design component. A data model that will effectively tell the story of the service line performance must have the following characteristics:

- Starts with the end in mind
- Structured for the understanding of process breakdowns
- Uses claims data as the center "connector" for all data to enhance data drill through and insightful visualizations
- Takes advantage of episodic data to appropriately link data

Granular data allows for sophisticated visualization. Data visualization is the leading method for information recognition and actionable decision-making. Techniques that enable and enhance data visualization include:

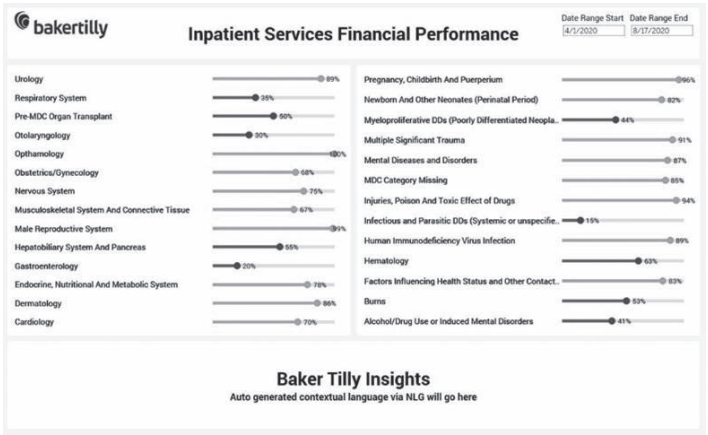
- Various alert level capabilities for lights out monitoring and early prevention
- Guided discovery concepts for efficient root cause analysis
- "On the fly" filtering / data review customization
- Embedded problem solving to improve user decisions
- "On the fly" data explanation to help users identify key data drivers to outcomes

Advanced analytics helps obtain the appropriate level of granularity. The integration of new data connections with augmented analytics allows operational modifications to improve outcomes, such as:

- Service line performance that explains provider practice patterns in conjunction with payer reimbursement outcomes as well as cost overlay analysis
- Using granular data while enabling machine learning to provide insights previously impossible to ascertain for multiple micro adjustments that in aggregate have significant financial impact

Advanced Analytical Concepts: Purpose built visualization with NLG insights

In the graphic below, while Gastroenterology has significant opportunity to improve performance, based on the sheer volume of cases, Respiratory Systems has the greatest potential for improved financial performance.

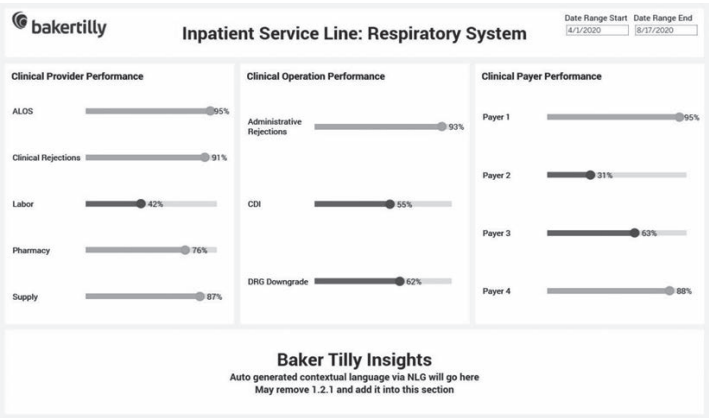


continued on page 46

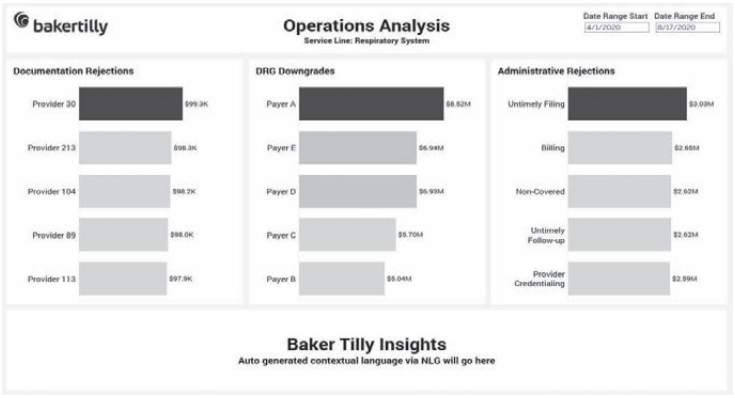
continued from page 45

The graphic below visualized that the labor component of Clinical Performance is underperforming due to the top performing physicians utilizing a higher level of clinical support resources than their respective peer group for cases with similar complexity.

Clinical documentation denials related to this service line are attributed to the top five providers in this peer group.



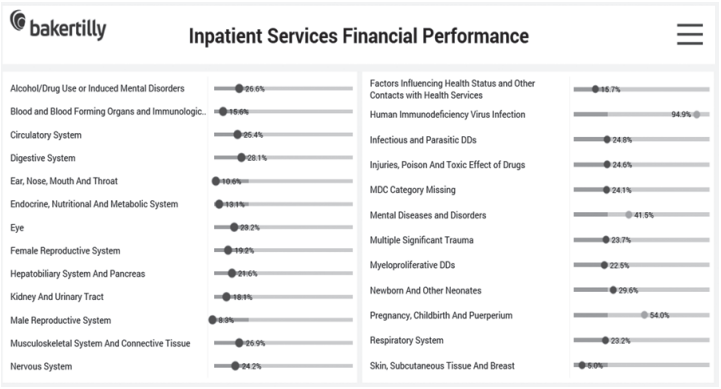
In the graphic below, Provider 30 experiences higher clinical documentation rejections than the related peer group for similar levels of complexity. Further, Provider 30 has a higher degree of DRG downgrades, predominately with Payer A.



Real world case study

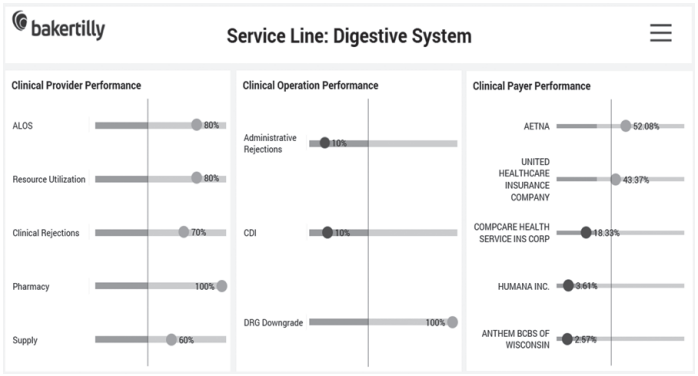
Digestive system service line: View of inpatient services

In this case study, visual data representation of inpatient services financial performance increased the speed to problem resolution. Visualization was based on a weighted scale of performance metrics. In the following data visualization graphic, DRGs related to Digestive Systems at 28.1% show significant opportunity for improvement.



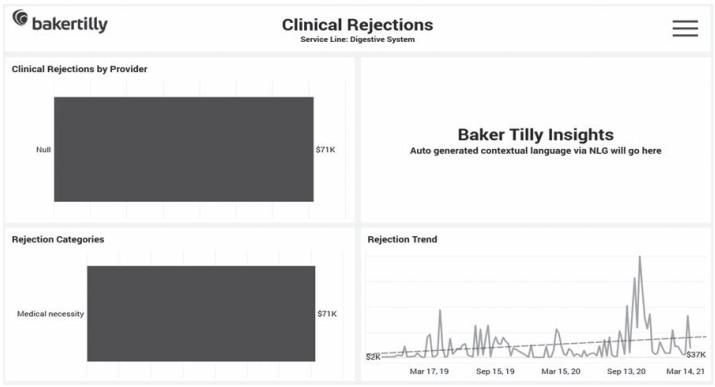
Digestive system service line: Performance drivers

Visualization of performance drivers indicates that overall activities are within an acceptable range; however, as illustrated below, opportunity to improve exists across the full spectrum except for DRG coding outcomes as illustrated in the following data visualization graphic.



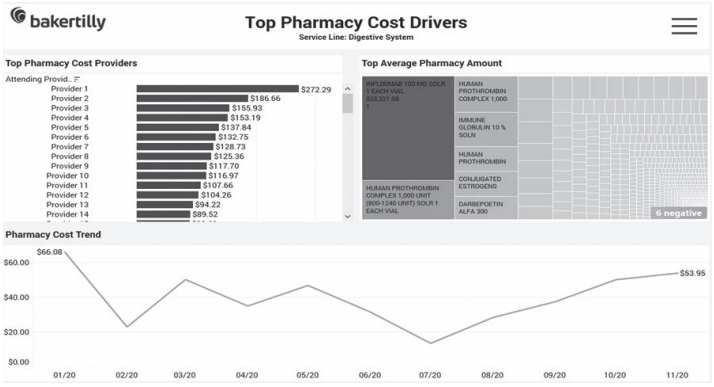
Digestive system service line: Clinical rejections

Drilling into clinical rejections can identify which physician is driving the highest level of Medical Necessity Denials that negatively impact overall service line financial performance. Below, note that Provider 12450834 has experienced the highest level of Medical Necessity rejections, and this is spread across 20 cases for this time period. Most notably, 72% of rejections are related to the specific payer indicating an opportunity to quickly improve documentation and preclearance to improve performance. The following data visualization graphic illustrates Medical Necessity rejections for Provider 12450834.



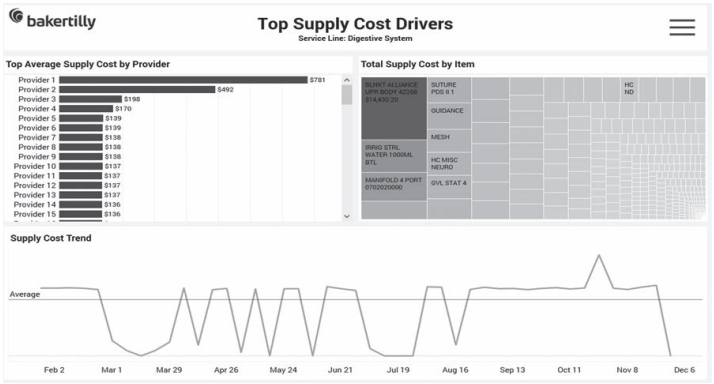
Digestive system service line: Top pharmacy cost drivers

Further analysis indicates that additional improvement can be made by in-depth study of the top underperforming providers as it related to Pharmacy expenses. As the following graphic illustrates, Provider 1 has a much higher Pharmacy expense average per case than their peers.



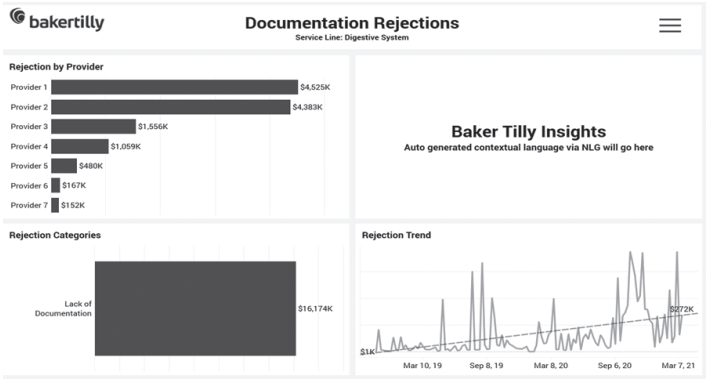
Digestive system service line: Top supply cost drivers

Similar to the above Pharmacy expense, Provider 1, as illustrated in the following data visualization graphic, also had a higher per case average Supply cost. The client was able to isolate those items and work with the Provider to normalize Supply usage patterns to be more in line with the associated peer group.



Digestive system service line: Documentation rejections

Another aspect of service line performance that is typically overlooked when not using granular data is the amount of rejections for cases that drive down overall service line profitability. The client in this case study was able to identify trends with specific providers and make immediate changes that improved service line profitability and drove down operational costs related to denial appeal processing. The following data visualization graphic shows that Provider 1 and Provider 2 have experienced the highest level of Missing Documentation denials spread across 29 cases for this time period. Most notably, 59% are related to the specific payer. A review of the documentation requirements with the Provider Representative should be conducted and then educational efforts planned with the providers to ensure compliance with payer requirements.



Conclusion

As illustrated by the case study, visual data representation facilitated the analysis of the digestive systems service line, increasing the speed to corrective actions. Service line analysis must be based on accurate and reliable data and should be performed regularly to identify trends. When conducting a rigorous analysis of a hospital's service, as illustrated by the case study, visual data representation expedited the analysis of the digestive systems service line, increasing the speed to corrective actions. Service line analysis must be based on accurate and reliable data, and should be performed regularly to identify trends. Whereas conducting a rigorous analysis of a hospital's service lines is key to planning for future profitability and sustainability, understanding service lines within the context of a hospital's service-line mix and the hospital's overall business is important. Decision-makers need to consider the best service mix for the populations served, services in relationship to potentially related conditions/services and competitor's offerings. Leaders need to evaluate if eliminating a service line or investing to improve the service line is the appropriate strategy.

continued on page 48

continued from page 47

About the Authors

Michael L. Duke is Principal, Healthcare Consulting. He has diverse experience and a record of accomplishment in leading people, programs, improving operational outcomes, and developing best management practices within the healthcare industry for over 26 years. He has led several successful engagements that demonstrated an ability to develop and execute executive level strategies. Recognized for professionalism, commitment to excellence, and ability to communicate and work with senior management, associates, and customers. He has proven expertise in the areas of operational innovation, operations management, corporate performance management and revenue cycle management. He can be reached at michael.duke@bakertilly.com.

David A. Gregory is Principal, Healthcare Consulting. He has a diverse healthcare background, ranging from hospital operations management to managed care underwriting/pricing to value-based care (VBC) models and partnerships. David is responsible for directing projects for all healthcare client types, including hospitals, health plans, and life sciences and technology companies. His specialties include financial analysis and reimbursement modeling, strategic planning and marketing, new technology value analysis and market access assessments, and VBC models and partnerships. David can be reached at david.gregory@bakertilly.com.

Mary Ellen Kasey is Senior Consultant, Healthcare Consulting. She has a background in healthcare management and financial administration with extensive practical managed care experience. She is responsible for projects in managed care contracting strategies, network development, managed care financial policy and reimbursement analysis, revenue cycle review and improvement strategies, operations and utilization management, physician practice management and practice valuations. Mary Ellen can be reached at maryellen.kasey@bakertilly.com.

Broken Bones and Bribes Give Birth to Better Risk Management

Kevin McPoyle, CPA

by Kevin McPoyle, CPA

One chilly Saturday afternoon in November 1960 a college freshman football player would break his leg in a game day tackle and risk management in healthcare would never be the same again. Dorrence Darling, an 18-year-old defensive halfback playing for Eastern Illinois University was rushed to a hospital where a doctor diagnosed his multiple fractures of the right tibia and fibula. The doctor set the bones and casted Mr. Darling's leg, but it would not end well for the patient. Four months later, an infection and excessive deterioration caused by the way the cast was set required the amputation of the young athlete's leg. The patient sued not only the doctor, but he sued Charleston Community Hospital where the doctor had treated him.

Up to this point in US healthcare history, malpractice had been limited to medical professionals. Hospitals were considered only conduits for doctors, a place to treat patients. Holding a hospital liable for failed medical decisions was like suing the landlord of the auto repair shop that botched your engine repair. But for five years following that fateful football injury, *Darling v. Charleston Community Hospital* was vigorously litigated all the way to the Illinois Supreme Court where that court would be the first in the nation to conclude vicarious liability does exist for hospitals. Medical malpractice lawsuits boomed over the preceding decades as a whole cottage industry of lawyers would specialize in targeting deep pocketed heath systems with easy to exploit shortfalls in overseeing how physicians treat their patients.

Risk Management in Healthcare is Born

A health system's only defense was to purchase ever greater amounts of malpractice insurance to mitigate the risk of lawsuits. Insurance premiums skyrocketed through the 1970's and 1980's. Some hospitals turned to the use of captives where they would fund their own insurance through an offshore entity. Eventually, to manage all this cost, hospitals had to become more proactive in limiting the number of lawsuits that came their way. Hospital administrators charged with managing insurance cost became dually appointed risk managers. They would analyze past malpractice claims and isolate specific root causes that made the hospital liable in those claims. The risk managers would then raise awareness about these root causes to help prevent the hospital from losing a similar claim going forward. This original approach to managing risk was rudimentary but valuable none the less. This approach was helpful not only in limiting legal liability but also in pinpointing improvements for patient safety and quality of care. The healthcare industry became increasingly interested in reducing medical errors and improving patient safety. Medical errors were often viewed as the underlying biggest cost of healthcare and numerous industry and government research would uphold that belief. But this "airplane crash approach" to risk management – wait for a catastrophe to happen and analyze it to see what can be done better next time – was not the most effective way to manage risk. Hospital risk managers started looking for a more rigorous model that would enable them to see weaknesses in their system before a catastrophe resulted. A very disparate and peculiar situation would eventually give them this model.

Bribery Scandal Leads to New Risk Model

One Winter Day in 1975 Eli M. Black, a former rabbi and then CEO of the United Brands company, left a meeting at his company's office in the Met Life building in midtown Manhattan. Using his briefcase, he bashed the window of his 44th floor office, jumped through it, and plummeted down to Park Avenue. His shocking suicide instigated an international investigation into corporate bribery of foreign government officials, and coincidentally this led to the most robust risk management model to benefit companies everywhere.

Throughout the 1970's there was growing concern about US corporations growing into global conglomerates using corruption and bribery. Mr. Black's United Brands company

continued on page 50

continued from page 49

sparked perhaps the most disturbing outcome of this practice when it engaged in a $2 million bribe scheme with the president of Honduras.

Back then bribing a foreign official was not illegal in the US but often the companies engaged in this activity had good reasons to hide what they were doing. Details on who they were bribing and how much they were corrupting government officials would be damaging to corporate reputations as well as those of the people they were inducing. But the Securities and Exchange Commission (SEC) could not allow publicly traded corporations to hide and misrepresent millions of dollars in expenditures. When details of an SEC investigation into United Brands became public in 1975, the president of Honduras was overthrown in a violent uprising and the entire country fell into civil unrest. While Rabbi Eli Black engulfed in guilt, Congress became alarmed about the global disorder that can result from an unfettered US corporate environment pursuing foreign corruption. This led to the passage of the Foreign Corrupt Practices Act (FCPA) of 1977.

FCPA Recognized Need for Effective Checks and Balances

The FCPA banned bribery of foreign officials by US companies, but it also recognized that this practice was far reaching and entrenched and as such each company will need an internal system of checks and balances to restrain bad activity and control outcomes. Up to this point the concept of internal controls in business had been discussed on a somewhat theoretical basis but not much practical guidance was available. The FCPA instituted a national commission to study the concept and develop guidance for companies who were now mandated to implement internal controls. This Commission was headed by the former SEC Commissioner, James C. Treadway, Jr. and while its official name was the National Fraudulent Financial Information Commission, it was more often referred to as the "Treadway Commission." Accounting and fraud prevention experts across five industry associations joined the Treadway Commission. These associations – the American Institute of Certified Public Accountants (AICPA), the Institute of Internal Auditors (IIA), the American Accounting Association (AAA), the Institute of Management Accountants (IMA) and the Financial Executives International (FEI) – were known as the Committee of Sponsoring Organizations (COSO) of the Treadway Commission and they would produce the most extensive guidance on risk management.

The Treadway Commission's first report elucidated the need for a comprehensive system of internal controls as an essential business process. In 1992, COSO published its first Integrated Framework which provided a model to evaluate and improve internal controls. This COSO Integrated Framework was a seminal development, and it has been embraced by most major corporations as the standard for assessing and managing risk. Following infamous corporate scandals like Enron in the 1990's and the financial services meltdown of 2008, the COSO Integrated Framework was enhanced and refined to be an even more concrete tool.

COSO Integrated Framework Provides Better Understanding of Risk

As its name implies, the framework provides a structure. It gives a language and conceptual understanding for things that would otherwise be rather obstruse. The COSO Integrated Framework provides a way to grasp the interplay between risks and their counterbalance in internal controls. You can measure only those things you understand, so the framework allows you to effectively measure and assess risk.

In hospital risk management departments, the COSO Integrated Framework has been utilized to add rigor to their risk assessment process. The framework provides that desired proactive ability to pinpoint weaknesses in a system. As hospitals became increasingly interested in patient satisfaction measurements that impact their reimbursement, elements of the COSO framework were often utilized to address the risk of low patient satisfaction. If you ever seen a "Strive for Five" campaign in a hospital where employees are drilled to ask patients "If there are any reasons you would not give me a 5 in your survey, please tell me about it", you have seen a rigorous and proactive application of risk management.

Health systems have embraced risk management to address malpractice liability, reduce medical errors, and enhance patient satisfaction. But the same risk management approach can be applied to the countless other risks that impact our healthcare institutions. Effective management of internal controls are needed in Compliance, Privacy, IT, Revenue Cycle, Human Resources, and all across the enterprise. How do you prevent billing for services not rendered, or billing for a non-covered service? The answer is risk management. How do you ensure employees are sufficiently trained to do their jobs effectively? The answer is risk management. What if your efforts to build integrated value-based care causes a situation that can be interpreted as giving a patient a kickback or inducement that is not allowed under the law? The answer, you guessed it, is risk management.

A Vigorous Habit to Manage Risk

Effective risk management is about taking a systematized approach to define and assess what could go wrong and the

continued on page 52

Risky Business: Understanding HCCs

by Luke Bengel, CHFP

Luke Bengel, CHFP

Hierarchical Coding Categories, or more commonly called HCCs, are at the heart of reimbursement for Medicare Advantage beneficiaries. While the industry has been talking about implementing value-based care for years and many feel that we still have a long way to go, HCCs are making real impacts on providers' bottom lines today. Unfortunately, many in the industry do not truly understand the complexity of this model and its effect on reimbursement. Some may have never even heard of them. This article intends to shed some light on exactly how HCCs operate, at a high-level, and help more people expand their understanding of value-based reimbursement.

The premise of HCCs is based off risk adjustment. The theory here is that it takes different resources, time, and money to care for patients based on their health conditions. Risk adjustment payment models were mandated in the Balanced Budget Act of 1997 so this is not what most would call a new idea. However, it was not until 2004 that the first iteration of the HCC model was implemented by CMS. The model has been iterated upon every year since.

There are many ways to define health acuity, but the HCC model boils it down into one number called the risk adjustment factor, or RAF. The RAF has two components and is calculated using a regression model programmed in SAS. The model assigns a RAF coefficient which is then used to determine how much it should cost to care for that patient for a year. Annual healthcare costs are normalized to a a RAF score equal to one, equating to $9,365.50 for 2021[1]. Any RAF score other than one would simply be multiplied by $9,365.50 to determine that patient's estimated costs.

There are two elements used in calculating the RAF: demographic information and health conditions. The demographic component includes age, sex, Medicare eligibility, Medicaid eligibility, and reason for entitlement. These five variables combine to develop and indication of basic demographic risk. The second component is a patient's health conditions which are captured by the providers documentation and the corresponding ICD-10 diagnosis codes on the claim. Diagnosis codes map to HCCs. Each HCC is associated with a score. A patient can have one or many HCCs depending on the conditions that are documented. The demographic score and the condition score are then added together to determine a patient's RAF.

It is important to note that not all conditions and diagnoses are assigned to an HCC. Of the over 70,000 ICD-10 diagnosis codes, approximately 14% map to a category in this model. The model maintains that often acute conditions are not appropriate determinants of ongoing healthcare costs while chronic conditions are. A good example here would be a patient with diabetes. This is a chronic condition that will require treatment the rest of a patient's life. However, a patient who gets coded with ICD-10 W59.22XA – Struck by turtle, Initial encounter (one of my personal favorite diagnoses), will have that bump on their head go away over time and it is impossible to predict the immediate and downstream costs to treat that acute incident.

The other key point about the HCC model is that it allows for varying levels of severity of chronic conditions. Sticking with our diabetes example, HCC 19 – Diabetes without complications or HCC 18 – Diabetes with Chronic Complications could be assigned to a patient depending upon the condition's severity and the documentation of the provider. The condition is the same so a patient will only have one of the HCCs included in their RAF. In this instance, and any other conditions where this 'trumping' logic applies, the more sever (higher weighted) HCC will always be used.

The details of the HCC model and underlying calculations are complex, but the benefits of leveraging RAF scores are numerous. When providers take the time to accurately document a patient's conditions, it creates a more holistic picture of the patient's health across the entire continuum of care. If a patient's chronic a-fib is appropriately documented in their medical record, the orthopedist that the patient goes and sees can now make informed decisions regarding the patient's treatment plan knowing their entire medical background. Perhaps they forgo prescribing that additional blood thinner as the patient may already be taking one. Additionally, it helps providers be fairly compensated for the level of care that they are providing. Should one provider who is treating a panel of patients with severe chronic conditions be paid the same as one who

continued on page 52

continued from page 50

controls in place to prevent it. The effort to reduce malpractice insurance cost forced hospitals to engage in this activity. A legislative effort to combat foreign corruption led to the development of an authoritative and useful model on how to do these assessments. Using this model to assess and manage risks as a vigorous habit across the entire organization is the very concept of Enterprise Risk Management (ERM) and this broad structural approach is the next step for health systems. With ERM health systems can become highly reliable institutions that proactively manage risk.

Come learn how to build an ERM program at your organization during the 2021 HFMA NJ and Metro Philadelphia Chapters 45th Annual Institute. **Enterprise Risk Management Can Do More Than Improve Your Patient Satisfaction Scores:** ***A Practical Approach to Comprehensive ERM*** will be presented on Thursday, October 7th in Breakout Room #1 from 3:10pm to 4:00pm.

About the Author

Kevin McPoyle, CPA is a healthcare risk management and compliance professional who has assisted healthcare providers, both large and small, with developing systems to ensure compliance, revenue integrity, and operational efficiency. He is the Compliance Officer for AmeriBest Home Care in Philadelphia where he leads risk mitigation for a fast-growing company operating in the fastest growing segment of healthcare. Kevin is a past president of the Metropolitan Philadelphia Chapter of HFMA, as well as a member of the AICPA and the IIA. Questions and comments welcomed, email at kmcpoyle@ameribest.org

---

continued from page 51

only has patients that are in relatively good health? The model financially incentivizes provides to emphasize their documentation and make sure that each patient is getting the level of care that he / she needs.

There are, however, a few issues with the HCC model that should be noted as well. Number one is the double-edged sword of incentivizing payment for sicker patients. A quick google search will reveal the trouble various health plans and providers have found themselves in for coding more severe conditions for which they did not have the proper support. Providers are not educated about documentation guidelines in medical school and need to rely on the expertise of a certified risk coder (CRC) to avoid landing themselves in hot water with the OIG. Secondly, the HCC model only actually accounts for 12.46% of cost variation according to a CMS report to congress in 2018[2]. This means that the RAF score of a patient does not account for the roughly 87.5% of variables related to that patient's cost of care. Elements such as social determinants of health (SDOH) are absent from this model and prove that is far from the silver bullet to all our value-based needs.

There are many value-based care reimbursement models in place across the country today. They all have their own benefits and challenges, but all have the same goal of increasing value-oriented, outcomes-driven healthcare for our communities. There are significant dollars at play here and effectively documenting and managing your patients' conditions will prove incredibly lucrative in a world where it is becoming increasingly difficult to negotiate rate increases with payers. Although HCCs are far from perfect, they are one of the most prevalent risk algorithms, used in many programs, and it would be unwise not to have a solid understanding of how they can be leveraged for provider payment and member care coordination. Everyone in the industry will need to work together to ensure that these models are successful. Providers will need to embrace the changes in their workflows and documentation practices. Payers will need to have open conversations with providers on how they work together to reduce costs. Vendors will need to develop new solutions to assist both payers and providers in managing, administrating, and monitoring these new programs. Value-based care will only become more prevalent in the years to come. Our industry needs to have everyone on the same page and committed to the same goal. Understanding the mechanics of HCCs will improve financial performance in value-based care arrangements through risk-adjusted payments and strong patient care coordination

About the Author

Luke Bengel is a consulting manager at Lighthouse Healthcare Advisors. He has over 5 years experience in the healthcare industry with specific focus on payer contracting, value-based reimbursement and analytics. Luke lives in Baltimore, MD with his wife Melanie and their dog Ripken. Luke can be reached at lbengel@lighthouseha.com.

Footnotes

[1]"HCC Software V2421.86.21", CMS, 2021

[2]"Report to Congress: Risk Adjustment in Medicare Advantage", CMS, December 2018

I Tried My Best, Is That Enough? Insight Into the Angst of Hospital Leadership and CARES Reporting

Fred Fisher

by Fred Fisher

Thank you, healthcare providers, patient advocates, and dedicated hospital personnel providing access to care during the COVID-19 pandemic. The industry also greatly appreciates HHS's expeditious appropriation of over $180 billion supporting key hospital personnel, operations, and cashflow.

There is no doubt our healthcare system is challenged with a modern-day unprecedented event. Providers are delivering essential care while contemplating the cost of COVID-19, including its impact on hospital operations and future revenues. This article focuses on the challenges and recommendations of reporting COVID-19 expenses and lost revenues to HHS under the CARES Act, especially considering complexities of healthcare finance and reimbursement systems. There are three common and substantial concerns around reporting the use of CARES Provider Relief Fund (PRF) to HHS.

There is no doubt our healthcare system is challenged with a modern-day unprecedented event. Providers are delivering essential care while contemplating the cost of COVID-19, including its impact on hospital operations and future revenues.

I. Absence of comprehensive audit guidance (e.g., Single Audits, HHS, OIG). Without an explicit audit plan, providers worry about the vulnerability of CARES funding with industry variations in PRF audit determinations.

II. Complexities in hospital reimbursement (e.g., patient care revenue vs. grants and settlements). When evaluating revenue losses to apply toward their PRF, providers are challenged with discerning patient care from other revenue types within sophisticated payment programs.

III. Use and reporting of "Targeted" PRF payments between parent companies and subsidiaries (e.g., High-Impact, Safety Net, Rural). The ability for providers to retain targeted PRF is puzzling considering HHS instruction on the transfer of Targeted funds between subsidiaries and parent companies.

I. Absence of comprehensive audit guidance

In addition to audit of financials, due to the public health emergency, the CARES PRF is the first time many providers are also subject to a Single Audit[1]. Furthermore, providers may also be subject to an audit from HRSA, depending on the reported use of PRF amounts[2]. Providers are preparing for these audits by reviewing resources, including PRF Terms & Conditions, 6.11.21 Reporting Requirements, PRF FAQs, and information available through the HRSA PRF Reporting Portal.

Of note, HHS is providing audit guidance through the Office of Management and Budget (OMB) Compliance Supplement[3]. To date, the latest OMB Compliance Supplement was published in December 2020[4], with a to-be-released notice here containing "key line items and other information from the report that are subject to audit for audits of fiscal years ending on or after December 31, 2020." Although an updated Compliance Supplement has yet to be published by OMB, both OMB and HHS generally state PRF amounts are to recognize expenses or lost revenues in preventing, preparing, and

continued on page 54

continued from page 53

Table One

Allowable PRF COVID-19 Expenses			
OMB Compliance Supplement		**HHS Reporting Instruction**	
✓	Building or construction of temp. structures	✓	General & Administrative (G&A) Mortgage/Rent
✓	Emergency operation centers	✓	G&A Insurance
✓	Retrofitting facilities	✓	G&A Personnel
✓	Leasing of properties	✓	G&A Fringe Benefits
✓	Medical supplies and equipment	✓	G&A Lease Payments
✓	Increased workforce and trainings	✓	Other G&A
✓	Surge capacity	✓	Healthcare Supplies
		✓	Healthcare Equipment
		✓	Healthcare IT
		✓	Healthcare Facilities
		✓	Other Healthcare

responding to coronavirus. Table One lists categories of COVID-19 expenses provided by both OMB and HHS, having slight differences in descriptions.

HHS provides comprehensive instruction for reporting on PRF amounts. However, other complex healthcare concepts remain unaddressed. For instance, PRF instruction allows certain costs, like supplies. Supplies are clearly distinguishable and supportable for audit. Conversely, other indirect costs are co-mingled within daily operations and are indistinguishable with audit support that would likely be subject to interpretation. There is no clear category (above, in Table One) to report indirect costs, unless they are reported as "Other Healthcare" – which HHS lists as a category, but not noted as a category on OMB's Compliance Supplement.

Consider the indirect cost associated with excessive patient length of stay (LOS). While the PRF explicitly covers direct expenses, like associated supplies, the cost of a patient occupying the room is significant. During excessive LOS cases, patients receive sophisticated 24-hour care while incurring extensive laboratory tests, pharmaceutical treatment, and overhead costs. The occupied bed with excess LOS may occur during peak capacity, further preventing hospitals from seeing other patients in the same bed for a shorter stay of care. In addition to excessive LOS, other indirect costs like increasing employee burnout and turnover, and accelerated wear and tear on assets are adding to hospital costs.

Using precedent, Medicare recognizes indirect costs with the Indirect Graduate Medical Education (IME) program. The IME program subsidizes teaching hospitals' additional costs associated with interns and residents (I&R) due to cost-inefficiencies (like excess lab-tests) incurred as an essential part of learning. Since there is no accounting mechanism clearly distinguishing I&R indirect costs, CMS developed its own convoluted formula identifying indirect costs for IME reimbursement. Other payers also recognize indirect costs, for instance, academic hospitals may be assigned an indirect cost factor when rate setting with state and commercial payers, and providers may apply for grants covering the indirect cost supporting novel care programs. Bottom line, indirect costs are actual and material. However, providers are concerned about the allowability of indirect expenses without a standard approach in how these costs are reported. How will HHS and auditors audit these costs under deviations in how they may be reported?

In one respect, reporting of indirect cost is important for some providers to retain current PRF and demonstrate need for future PRF allocations. In another respect, the ability to demonstrate these costs for all providers is paramount to record the true cost of COVID-19 to the entire healthcare industry. Table Two includes recommendations assisting providers evaluate and report of indirect expenses related to COVID-19.

II. Reporting Patient Care and Other COVID-19 Revenue

As we have contemplated reporting indirect costs as a PRF expense, it is equally important to consider associated revenue impacted by COVID-19. Provider revenue is accounted for in two areas of CARES PRF reporting:

Table Two

Recommendations for Reporting Indirect COVID-19 Costs	
✓	Include a written narrative discussing indirect costs, with robust supporting workpapers.
	- Report indirect expenses as "other" healthcare expenses, ensuring this amount removes other amounts being reported to HHS as a direct COVID-19 expenses (to avoid double counting).
✓	Reduce the expense by all patient payments, such as outlier payments, that offset indirect costs (e.g., excessive LOS). It is important to account for this revenue against expenses in the event lost revenue in "Step 2" is not used for PRF. Any revenue offsetting expenses in Step 1 should not be accounted for in Step 2 revenue loss.
✓	Have open and continuous dialog with auditors, associations, other providers and industry leaders on COVID-19 expenses. Also consider discussing other "stranded costs" – like the increased cost of patient care providers – as it relates to current or future PRF.
✓	Refer to the HHS FAQ addressing marginal costs stating:
	- "The Provider Relief Fund permits reimbursement of marginal increased expenses related to coronavirus provided those expenses have not been reimbursed from other sources or that other sources are not obligated to reimburse"
✓	Evaluate areas of marginal costs not captured in the COVID-19 unit, including but not limited to:
	- costs related to excessive LOS
	- increase in sick and hazard pay
	- increase in screening and screening costs
	- increase in malpractice (and other insurance) costs
	- increase in PPE, pharmacy and lab cost
✓	Evaluate and remove marginal cost increases not related to COVID-19 (i.e., marginal costs from a new physician practice)
✓	Recall HHS views every patient as a possible case of COVID-19[5], providing an argument that each patient could be assigned COVID-19 expense.
	- For example, the hospital may have incurred costs for all patients – not just patients in the COVID-19 unit - related to excessive LOS (inability to discharge to post-acute care), with additional screening and housekeeping costs. These costs associated with patients in a non-COVID-19 unit should be considered for PRF reporting.

1. Revenue reporting against COVID-19 expenses in "Step 1": accounting the use of PRF towards COVID-19 expenses net of "other revenue received (or obligated to receive)"

and

2. Quarterly revenue evaluation comparing CY 2020 and CY 2021 vs. quarterly amounts from CY 2019 in "Step 2": accounting revenue loss towards the use of PRF.

Revenue against COVID-19 expenses in "Step 1" of PRF Reporting

HHS notably highlights it is the provider's burden to subtract other COVID-19 revenue reimbursed or obligated to be reimbursed from another source from PRF expenses. HHS Instruction also requires providers to report categories of other assistance in a separate area of PRF reporting (per Table Three 0n next page). It is however unspecified if HHS expects the categories of "other assistance" to be the same amounts providers use to offset against COVID-19 expenses.

Absent from Other Assistance Received above in Table Three is mention of revenues directly related to patient care. In a PRF FAQ[6] HHS asserts patient care revenue should not be reported as "other assistance received," stating:

> *"Patient care revenue should not be reported as part of "Other Assistance Received" as it is a source of revenue, not a source of other assistance as defined by Provider Relief Fund reporting requirements."*

Omitting patient care revenue as "Other Assistance Received" is helpful so revenue amounts are not counted twice against PRF (offsetting expenses and again as patient care revenues). However, this instruction is perplexing and contradictory when reviewing an earlier HHS FAQ[7] denoting sources of other revenue, including:

> *"…any amounts received through other sources, such as direct patient billing, commercial insurance, Medicare/Medicaid/Children's Health Insurance Program (CHIP)…"*

Perhaps this is a good time to reference OMB's Compliance Addendum highlighting FAQs are not a reliable source of PRF instruction:

continued on page 56

continued from page 55

Table Three

HHS Categories of Other Assistance Received	
✓	Department of the Treasury (Treasury) and/or Small Business Administration (SBA) Assistance
✓	Federal Emergency Management Agency (FEMA) Programs
✓	HHS CARES Act Testing
✓	Local, State, and Tribal Government Assistance
✓	Business Insurance
✓	Other Assistance

"Such guidance [FAQs] is issued to communicate an agency's understanding of how the relevant statutes, regulations, or the terms and conditions of the federal awards to the extent they exist and apply to a particular circumstance, but it does not create new compliance requirements. Due to the evolving nature of the pandemic environment, it has been common for federal agencies to update, change, or delete their specific guidance over time..."

Recommendations Reporting Other Assistance Received

Providing recommendations under seemingly conflicting FAQs is challenging. Nevertheless, under the guise of recognizing all non-PRF COVID-19 payments, it is recommended amounts from HHS categories of "other assistance" (per Table Three) are used to offset COVID-19 expenses.

It is also recommended patient care COVID-19 revenue (e.g., CMS' 20% DRG add-on, outlier payments, etc.) are accounted for in the determination lost revenue (quarterly revenue in 2020, 2021 vs. revenue in 2019). However (as discussed in Section I), providers reporting indirect costs have a caveat. In the event other revenue (like outlier payments) is related any reported indirect costs (e.g., excessive LOS), providers should account for this revenue in Step 1 to net against expense, and not double count in the Step 2 revenue tally. This recommendation is to ensure revenue related to any reported indirect costs is accounted in PRF reporting, especially in the event only expenses in Step 1 (and not lost revenues in Step 2) are used to absorb PRF

Providers should maintain workpapers and open dialog with their auditors showing how all other COVID-19 assistance is accounted against PRF. An accompanying narrative supporting this approach, or any other reporting approach, is also judicious. The narrative should reference the specific applicable HHS Instructions and/or FAQ. Providers may choose to highlight that patient care payments are typically made on a per-discharge basis (i.e., Medicare IPPS), with no linear relationship to direct itemized expenses. Therefore, there is no correlation for reporting patient care revenue as "other assistance received" (reducing COVID-19 expenses in Table One), and this revenue accounted for in the determination of quarterly revenue loss in "Step 2" of PRF reporting.

Quarterly revenue loss accounted towards PRF in "Step 2" of HHS Reporting

In "Step 2" accounting for the use of PRF, providers have the option[8] to report patient care revenue comparing quarterly amounts by payer from CY 2020 and CY 2021 against quarterly amounts from 2019. HHS PRF Reporting Instruction describes patient care revenue including amounts:

"prior to netting with expenses…health care, services and supports, as provided in a medical setting, at home/telehealth, or in the community."

HHS PRF Instruction describes patient care revenue excluding amounts related to:

"non-patient care revenue such as insurance, retail, or real estate revenues (exception for nursing and assisted living facilities' real estate revenues where resident fees are allowable); prescription sales revenues (exception when derived through the 340B program); grants or tuition; contractual adjustments from all third-party payers; charity care adjustments; bad debt; and any gains and/or losses on investments."

Much of HHS's revenue reporting requirements are straight forward. However, the instructions become murky when isolating patient care revenue impacted by COVID-19. For instance, providers may record revenue one period (i.e., Q2 of 2020), whereas the care relates to another period (i.e., Q3 of 2019). In order to provide an "apples to apples" comparison of patient care revenue, providers are evaluating whether to omit or reallocate these payments.

Importantly, HHS permits providers to remove skewed rev-

enue per an FAQ[9] regarding fluctuations in year-over-year net patient revenues due to settlements or payments made to third parties relating to care delivered outside the reporting period (2019-2021). HHS states:

> *"Provider Relief Fund recipients shall exclude from the reporting of net patient revenue payments received or payments made to third parties relating to care not provided in 2019, 2020, or 2021."*

The HHS FAQ above is surely helpful, yet concerns remain on unaddressed technicalities associated with misaligned revenue. In many cases, these concerns derive from multifaceted Medicaid supplemental payment programs. For example, providers inquire if they may:

- Realign and restate revenue within 2019 through 2021, representing the period(s) when care was provided (as compared to when revenue was recorded).
- Omit revenue from programs subject to CMS approval (i.e., renewal of 1115 Waiver programs). Although providers may receive interim payments, actual payments are not determined until CMS approves the respective program. Providers have limited or no means of assessing and reserving for these payments during PRF reporting periods until these programs are approved and rolled out by their respective States.

Recommendations Reporting "Misaligned" Patient Care Revenue

It is recommended providers account for misaligned revenue before reporting quarterly amounts to HHS. Re-appropriation of misaligned payments may provide a more accurate depiction of COVID-19 and its impact to provider revenue. For providers looking to report year over year changes as revenue loss (HHS PRF reporting "Option i"), it is important to discuss revenue adjustments with auditors. Providers and auditors should assess whether it is appropriate to report patient care revenue – adjusted for misaligned revenue – under "Option i" (year over year changes) or under "Option iii" (other). Reporting under option iii increases likelihood of HRSA audit, but also provides the opportunity to include a narrative to HHS. Regardless, a strong narrative and workpaper set is recommended for any option.

III. Reporting Targeted Payments Between Parent Company and Subsidiaries

Since April of 2020, providers received different types of CARES PRF allocations. HHS distinguishes these payments as "General" and "Targeted" allocations. General payments were appropriated to any provider agreeing to the Terms & Conditions of the CARES PRF and relate to funding from "Phases 1 through 3." Targeted payments, specifically related to High-Impact, Safety Net and Rural, were only appropriated to providers HHS identifies as eligible for these payments. For instance, HHS determined providers eligible for Targeted Safety Net payments using (unaudited) Medicare cost report data from 2018/2019, and qualified hospitals based on thresholds related to disproportionate share (DSH), Uncompensated Care (UC), and profitability margins. Targeted Rural payments were disbursed based on provider status, utilization and expenses reported on Medicare cost report. Targeted High-Impact funding was determined by a qualifying threshold of COVID-19 patients. In large part, Targeted payments were applied using approximate data.

More accurate than using approximate data, health systems tap into their accounting systems and teams to pinpoint subsidiary providers especially impacted by COVID-19. In some cases, to direct funds to the greatest need, providers look to transfer Targeted payments from a subsidiary to the parent company. However, HHS reporting instructions are ambiguous regarding if and how subsidiaries may transfer Targeted payments to their parent company. HHS Reporting Instruction states:

> *"The original recipient of a Targeted Distribution payment is always the Reporting Entity. A parent entity may not report on its subsidiaries' Targeted Distribution payments. The original recipient of a Targeted Distribution must report on the use of funds in accordance with the CRRSA Act. This is required regardless of whether the parent or subsidiary received the payment or whether that original recipient subsequently transferred the payment. A Reporting Entity that is a subsidiary must indicate the payment amount of any of the Targeted Distributions it received that were transferred to/by the parent entity, if applicable. Transferred Targeted Distribution payments face an increased likelihood of an audit by HRSA."*

Providers are confounded by the HHS instruction that "a parent entity may not report on its subsidiaries' Targeted Distribution payments" while also stating "a Reporting Entity that is a subsidiary must indicate the payment amount of any of the Targeted Distributions it received that were transferred to/by the parent entity, if applicable."

Furthermore, an HHS FAQ[10] indicates parent companies have more latitude transferring Targeted payments so they may "control and allocate that Targeted Distribution payment among other subsidiaries that were not themselves eligible and did not receive a Targeted Distribution." This FAQ also states,

continued on page 58

continued from page 57

"the parent company may allocate the Targeted Distribution up to its pro rata ownership share of the subsidiary to any of its other subsidiaries that are healthcare providers."

Hypothetically, assume a two-hospital health system with separate TINs.

- Hospital A is the parent entity and received $0 Targeted PRF
- Hospital B is the subsidiary and received $50M in Targeted PRF
- Hospital B transfers $20M in its targeted funds to Hospital A.

HHS instruction is clear that $20M may not be reported by Hospital A (parent entity). How then does Hospital B transfer these payments "to/by the parent entity," so that the proper entity reports on the use of $20M in funds?

Recommendations on Transfer of Targeted PRF

The primary recommendation concerning uncertainty is disclosure. It is recommended both the parent company and subsidiary include narrative and supporting workpapers on the transfer of funds. Transfer of Targeted funding should also be discussed during meetings with auditors. Hopefully, HHS will issue further guidance providing additional instruction or clarity on this reporting concern.

Ambiguity associated with $182.5bn in funding is not ideal, but – as we have learned - to be expected during the unprecedented events of COVID-19. The healthcare industry should continue to seek answers to hard questions, and at the same time provide crucial education to HHS, auditors, and anyone else in a decision-making position on PRF allotments. In the end, open communication, transparency, and solid workpapers are the best approaches for addressing the unknown.

About the Author

Fred Fisher is VP Service Development at Toyon Associates, Inc. He can be reached at fred.fisher@toyonassociates.com.

Footnotes

[1]Recipients that expend a total of $750,000. Non-profit providers under 45 CFR 75.514; commercial under 45 CFR 75.216(d) or 75.501(i)

[2]HHS Reporting Instruction includes providers reporting under "Option iii" applying an "alternative" approach for reporting revenue loss and providers transferring targeted payments.

[3]PRF FAQ "Will HHS provide guidance to certified public accountants and those organizations that providers will rely on to perform audits? (Modified 6/11/2021)"

[4]2 CFR PART 200, APPENDIX XI COMPLIANCE SUPPLEMENT ADDENDUM - DEPARTMENT OF HEALTH AND HUMAN SERVICES CFDA 93.498 PROVIDER RELIEF FUND

[5]PRF FAQ "Will patient care revenue be counted against a Reporting Entity twice if the entity reported in "Other Assistance Received" and in the "Patient Care/Lost Revenue" sections of the Reporting Portal? (Added 7/1/2021)

[6]PRF FAQ "How do I determine if expenses should be considered "expenses attributable to coronavirus not reimbursed by other sources?" (Modified 6/11/2021)"

[7]Providers may also report lost revenues comparing actual revenue in 2020 and 2021 to budgeted revenue, or under any "other" method (requiring a narrative and calculation).

[8]PRF FAQ "Providers may have significant fluctuations in year-over-year net patient revenues due to settlements or payments made to third parties relating to care delivered outside the reporting period (2019-2021). Should Provider Relief Fund recipients exclude from the reporting of net patient revenue payments received for care not provided in 2019, 2020, or 2021? (Modified 7/1/2021)"

[9]PRF FAQ - Can a parent organization with a direct ownership relationship with a subsidiary that received a Provider Relief Fund Targeted Distribution payment control and allocate that Targeted Distribution payment among other subsidiaries that were not themselves eligible and did not receive a Targeted Distribution (i.e., Skilled Nursing Facility, Safety Net Hospital, Rural, Tribal, High Impact Area) payment? (Modified 1/28/2021)

Wednesday - October 6th

Opening Session with Lunch:	**12:00pm to 1:40pm**	(2 CPEs)	BallRoom
Attacking Medicare Advantage Denials - Taking Your Power Back Day Egusquiza, AR Systems, Inc			
Break:	**1:40pm to 2:00pm**		Vendor Hall
Ice Cream Social/Vendor Hall Opening			
Breakout 1:	**2:00pm to 2:50pm**	(1 CPE)	
Artificial Intelligence (AI) in the Healthcare Revenue Cycle Matthew Schwartz, FTI Consulting Brett Barlag, FTI Consulting			Room #1
Strategies in an Environment Where Negotiated Rates are Public Govind Goyal, Panacea Healthcare Solutions			Room #2
Best Practices to Combat Denials: Keep Calm and Appeal Like a Lawyer Sarah Mendiola, Cloudmed			Room #3
Accounting, Auditing and Provider Relief Fund Update Michael Serluco, Withum Domenic Segalla, Withum			Room #4
Break:	**2:50pm to 3:00pm**		
Transition			
Breakout 2:	**3:00pm to 3:50pm**	(1 CPE)	
Compliance, Privacy and Regulatory Considerations for your SDOH Program Danette Slevinski, University Hospital John Barry, Epstein Becker Gree"			Room #1
Aligning Physician and Hospital Incentives to Support Recovery and Transformation Jo Surpin, Applied Medical Software			Room #2
Revenue Cycle Vendor Management Optimization John Marchisin, AArete			Room #3
Ensuring Quality Services & Cost Savings Serving the Intellectual and Developmentally Disabled Community Valerie Sellers, New Jersey Association of Community Providers Thomas Papa, Apis Services, Inc.			Room #4
Break:	**3:50pm to 4:10pm**		
Coffee/Beverage Break			Vendor Hall
Breakout 3:	**4:10pm to 5:00pm**	(1 CPE)	
Trends in Fraud and Abuse Investigations Since COVID Jack Wenik, Epstein, Becker and Green			Room #1
Data Analytics: A Roadmap to Actionable Data Jeff Lambert, Organizational Intelligence John Cornelius, Organizational Intelligence			Room #2
A Revolutionary approach to managing revenue cycle performance Kyle McMahan, Baker Tilly			Room #3
Healthcare Industry Tax Update 2021 Hayley Shulman, Withum John Smith, Withum			Room #4
Charity Event:	**6:00pm to 7:30pm**		
NJ Sharing Network			Vendor Hall

Thursday - October 7th

Breakfast:	**8:00am to 9:00am**		BallRoom
Buffet Breakfast			
Awards:	**8:45am to 9:00am**		
Awards Ceremony			
Stacey Mederios, Past President, NJ HFMA			
General Session:	**9:00am to 9:50am**	(1 CPE)	BallRoom
What to Expect Now That Cannabis is Legal			
Sarah Trent, Valley Wellness			
Seth Tipton, Florio Perrucci Steinhardt Cappelli Tipton & Taylor LLC			
Jan Roberts, DSW, LCSW			
General Session:	**9:50am to 10:40am**	(1 CPE)	BallRoom
Innovate. Create. Grow.			
Michelle Histand, Independence Blue Cross			
Break:	**10:40am to 10:50am**		Vendor Hall
Small Snack			
Keynote Session:	**10:50am to 12:05pm**	(1.5 CPEs)	BallRoom
The Covid-19 Pandemic: What have we learned and where do we go from here?			
Edward Eichhorn, Healing American Healthcare Coalition			
John Dalton, Healing American Healthcare Coalition			
Lunch:	**12:05pm to 1:05pm**		BallRoom
Buffet Lunch			
Lunch and Learn:	**12:10pm to 1:00pm**	(1 CPE)	
Win the Remote Revenue Cycle Future			Room #1
Wendell White, HealthRev Advisors, LLC			
Value-based Care in Biden's First 100 Days and Beyond			Room #2
Moshe Starkman, Star Tech Partners			
What's your risk? Understanding HCCs is Risky Business			Room #3
Luke Bengel, Lighthouse Healthcare Advisors			
Breakout 4:	**1:05pm to 1:55pm**	(1 CPE)	Room #1
Hot Topics in Compliance			
Robert Bacon, Penn Medicine			
COVID-19 Cost Recognition and the CARES Provider Relief Fund			Room #2
Scott Besler, Toyon Associates			
Fred Fisher, Toyon Associates			
Turn Denials Into Dollars - Optimize Insurance Revenue			Room #3
Karlene Dittrich, MEDREVENUE SOLUTIONS, LLC			
Aligning your Managed Care Contracting with your Organization's Strategic Plan for Growth			Room #4
Sam Donio, CBIZ KA Consulting Services, LLC			
Brian Herdman, CBIZ KA Consulting Services, LLC			
Breakout 5:	**2:00pm to 2:50pm**	(1 CPE)	
The New Health Industry Cybersecurity Practices (HICP) Rule along with Simplifying IT Environments Helps Organizations Reduce Cyber Risk			Room #1
Gerry Blass, ComplyAssistant			
Jason Tahaney, Community Options			
Modeling Physician Compensation Related to the New E&M Office Visit Regulations			Room #2
Stacy Pereira CBIZ KA Consulting Services, LLC			
Rupal Trivedi, CBIZ KA Consulting Services, LLC			
Deciphering Coding Denials			Room #3
Malissa Powers, Revecore			
New Medicare Cost Report Instructions, Worksheets and Data Templates - An In-Depth Review to Adapt Existing Protocols			Room #4
Michael Newell, Moss Adams			
Jonathan Mason, Moss Adams			

Breakout 6: **3:10pm to 4:00pm** (1 CPE)

Enterprise Risk Management Can Do More Than Improve Your Patient Satisfaction Scores: A Practical Approach to Comprehensive ERM — Room #1
Kevin McPoyle, AmeriBest Home Care

Hospital Analytics - Stories from The Front line. — Room #2
John Nettuno, St. Joseph's Health

Utilization Management - The Revenue Cycle Blind Spot: How to Leverage Data to Prevent Revenue Loss — Room #3
Joseph Zebrowitz, Versalus Health
Jerilyn Morrissey, Versalus Health

Leveraging Price Transparency Data For Payer Negotiations — Room #4
Tara Bogart, PMMC
Greg Kay, PMMC

Breakout 7: **4:10pm to 5:00pm** (1 CPE)

Key Performance Indicators in Utilization Review - Is No Data Better than Bad Data? — Room #1
Ronald Hirsch, R1 RCM, Inc

Mining For Margin: Learning Financial Transformation Lessons With Data Science — Room #2
John Budd, ECG Management Consultants
Curtis Leung, ECG Management Consultants — Room #3

COVID-19 CMS Updates: Billing and Impact on Transfers
Mary Devine, BESLER

Creating Liquidity Through the Sale of Ancillary Business Segments — Room #4
Kirk Rebane, Haverford Healthcare Advisors
Christopher Jahnie, Haverford Healthcare Advisors
Rick Cooper, McDonald Hopkins
Christal Contini, McDonald Hopkins

Break: **5:00pm to 6:00pm**
Free Time
President's Reception: **6:00pm to 8:00pm**

Beer Garden Appetizers will be served
Late Night Event: **10:00pm to 1:00am**
Premier Night Club
"Enjoy Networking, Music and Dancing"

Friday - October 8th

Breakfast: **8:00am to 9:00am**
Buffet Breakfast — BallRoom

General Session: **9:00am to 9:50am** (1 CPE)
Stop Procrastinating & Start Producing — BallRoom
Sandra Lane, Organization Lane, LLC

General Session: **9:50am to 10:40am** (1 CPE)
Where the Health Care Dollar is Spent? — BallRoom
Wardell Sanders, NJ Association of Health Plans

Break: **10:40am to 10:50am**
Drinks — BallRoom

General Session - Panel: **10:50am to 12:05pm** (1.5 CPE)
Lessons learned and post-pandemic recovery efforts for hospitals and health systems — BallRoom
"C" Suite Panelists:
Amy Mansue, President, Inspira Health Network
Herb White, Chief Financial Officer, Hunterdon Healthcare
Garrick Stoldt, CFO, St. Peter's University Healthcare System
David Gregory, Baker Tilly

hfma™

new jersey chapter

2020-2021 Chapter Internal Financial Review

HFMA requires that each Chapter conduct either an independent audit or an HFMA Internal Financial Review. The HFMA Internal Financial Review process and reporting were developed by HFMA and must be followed by any Chapter opting for this approach instead of an independent audit. Pursuant to HFMA's requirements, the Internal Financial Review must be completed by an individual or individuals possessing the appropriate financial experience and who are not involved in the Chapter's bookkeeping activities.

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

- Addresses whether the Chapter's Financial Statements correctly reflect the activities for the year.
- Consider whether an adequate level of documentation is maintained for the Chapter's receipt and disbursement transactions in order to reconcile checking and saving account bank statements.
- Considers whether transaction approval guidelines are in place and being observed.

The Internal Financial Review for the 2020–2021 Chapter Year was completed on a voluntary basis by a Certified Public Accountant who is a member of the Chapter. The Chapter Treasurer, the Assistant Treasurer and Officers provided the necessary documentation required for the Internal Financial Review. The completed Internal Financial Review questionnaire was provided to the Chapter's Audit Committee of the Board of Directors. A meeting of the Audit Committee was held to review the findings and the questionnaire. Upon review, the Audit Committee accepted the Internal Financial Review findings and approved the Financial Statements for the 2020–2021 Chapter Year.

The accompanying Balance Sheets and statements of Activities and Cash Flows for the years ended May 31, 2021, 2020 and 2019 reflect the Financial Statements for the NJ Chapter. If you should have any questions, please feel free to reach out to any Board member for assistance.

The pandemic posed unprecedented challenges to us all, and I want to take this opportunity to thank the Chapter Leadership for continuing to fulfill our mission in educating our members during a time of uncertainty and disruption while also providing numerous networking events that allowed us to stay in contact with our friends and colleagues. This is a time like no other, and I'm proud to be a part of an organization that rose to the challenge.

Respectfully submitted,

Michael P. McKeever, CPA, FHFMA
2020-2021 Audit Committee Chair
NJ HFMA

Healthcare Financial Management Association - New Jersey Chapter
Balance Sheets

	May 31		
	2021	2020	2019
Assets			
Current Assets			
Bank accounts	$ 254,663	$ 269,780	$ 343,308
Accounts receivable, net	2,800	785	17,260
Other current assets	12,247	23,024	19,587
Total current assets	269,710	293,589	380,155
Investments	25,867	-	-
Fixed assets	-	-	-
Total assets	$ 295,577	$ 293,589	$ 380,155
Liabilities and net assets			
Liabilities			
Current liabilities			
Accounts payable	$ 4,290	$ 1,921	$ 58,533
Deferred revenue	14,646	15,188	41,220
Accrued payroll	1,957	2,042	4,470
Total current liabilities	20,893	19,151	104,223
Total liabilities	20,893	19,151	104,223
Net assets			
Net assets without restriction	274,684	274,438	275,932
Total liabilities and net assets	$ 295,577	$ 293,589	$ 380,155

Healthcare Financial Management Association - New Jersey Chapter
Statements of Activities

	Year ended May 31		
	2021	2020	2019
Income			
Meeting and education income	**675**	**167,167**	**188,956**
Newsletter income	**16,980**	**25,065**	**26,940**
Golf Outing Income	**35,690**	**-**	**55,555**
General sponsorship income	**77,781**	**183,129**	**193,877**
Interest income	**80**	**2,098**	**3,089**
Other income	**166**	**20**	**182**
Total income	**131,372**	**377,479**	**468,599**
Expenses			
Meeting and education expenses	**43,951**	**288,132**	**337,408**
Newsletter expenses	**18,286**	**25,154**	**29,527**
Golf Outing expenses	**26,900**	**297**	**47,071**
Member recognition and social event expenses	**2,070**	**3,379**	**7,742**
General and administration expenses	**40,227**	**61,626**	**74,403**
Provision for bad debts	**595**	**385**	**245**
Total expenses	**132,029**	**378,973**	**496,396**
Net Operating Loss	**(657)**	**(1,494)**	**(27,797)**
Unrealized gain and loss	**903**	**-**	**-**
Net income (loss)	**246**	**(1,494)**	**(27,797)**

Healthcare Financial Management Association - New Jersey Chapter
Statement of Cash Flows

	Year ended May 31		
	2021	2020	2019
Operating activities			
Net income (loss)	**246**	**(1,494)**	**(27,797)**
Adjustments to reconcile net income (loss) to net cash provided by (used in) operations:			
Change in unrealized gains (net)	**(903)**	**-**	**-**
Accounts receivable, net	**(2,015)**	**16,475**	**(12,975)**
Other current assets	**10,777**	**(3,437)**	**21,510**
Accounts payable	**2,369**	**(56,612)**	**(2,093)**
Deferred Revenue	**(542)**	**(26,032)**	**17,618**
Accrued Payroll	**(85)**	**(2,428)**	**333**
Net cash used in provided by (used in) operating activities	**9,847**	**(73,528)**	**(3,404)**
Cash flows from Investing Activities			
Purchases of Investment, net	**(24,964)**	**-**	**-**
Net decrease in cash	**(15,117)**	**(73,528)**	**(3,404)**
Cash at beginning of period	**269,780**	**343,308**	**346,712**
Cash at end of period	**254,663**	**269,780**	**343,308**

Statement of Ownership, Management, and Circulation (All Periodicals Publications Except Requester Publications)

UNITED STATES POSTAL SERVICE®

1. Publication Title	2. Publication Number	3. Filing Date
Garden State Focus	1 0 7 8 7 0 3 8	09/20/2021
4. Issue Frequency	**5. Number of Issues Published Annually**	**6. Annual Subscription Price**
Every 3 months	4: 2 are mailed, 2 are posted online	NA

7. Complete Mailing Address of Known Office of Publication *(Not printer) (Street, city, county, state, and ZIP+4®)*
c/o CBIZ KA Consulting Services
50 Millstone Road, Bldg 400, Suite 100, East Windsor, NJ 08520

Contact Person: Laura Hess
Telephone *(Include area code)*: (908) 963-2505

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not printer)*
Healthcare Financial Management Association - NJ Chapter
PO Box 6422, Bridgewater, NJ 08807

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

Publisher *(Name and complete mailing address)*
Brian Herdman, c/o CBIZ KA Consulting Services
50 Millstone Road, Bldg 400, Suite 100, East Windsor, NJ 08520

Editor *(Name and complete mailing address)*
Scott Besler
3 Heather Lane, Bordentown, NJ 08505-4819

Managing Editor *(Name and complete mailing address)*
Scott Besler
3 Heather Lane, Bordentown, NJ 08505-4819

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

Full Name	Complete Mailing Address
Healthcare Financial Management Association,	PO Box 6422
New Jersey Chapter	Bridgewater, NJ 08807

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

Full Name	Complete Mailing Address

12. Tax Status *(For completion by nonprofit organizations authorized to mail at nonprofit rates) (Check one)*
The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
☑ Has Not Changed During Preceding 12 Months
☐ Has Changed During Preceding 12 Months *(Publisher must submit explanation of change with this statement)*

PS Form **3526,** July 2014 *[Page 1 of 4 (see instructions page 4)]* PSN: 7530-01-000-9931 **PRIVACY NOTICE:** See our privacy policy on *www.usps.com.*

13. Publication Title	14. Issue Date for Circulation Data Below
Garden State Focus	04/01/2021

15. Extent and Nature of Circulation			Average No. Copies Each Issue During Preceding 12 Months	No. Copies of Single Issue Published Nearest to Filing Date
a. Total Number of Copies *(Net press run)*				
b. Paid Circulation *(By Mail and Outside the Mail)*	(1)	Mailed Outside-County Paid Subscriptions Stated on PS Form 3541 (Include paid distribution above nominal rate, advertiser's proof copies, and exchange copies)	853	0
	(2)	Mailed In-County Paid Subscriptions Stated on PS Form 3541 *(Include paid distribution above nominal rate, advertiser's proof copies, and exchange copies)*	61	0
	(3)	Paid Distribution Outside the Mails Including Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Paid Distribution Outside USPS®		0
	(4)	Paid Distribution by Other Classes of Mail Through the USPS (e.g., First-Class Mail®)		0
c. Total Paid Distribution *[Sum of 15b (1), (2), (3), and (4)]* ▶			914	0
d. Free or Nominal Rate Distribution *(By Mail and Outside the Mail)*	(1)	Free or Nominal Rate Outside-County Copies included on PS Form 3541		0
	(2)	Free or Nominal Rate In-County Copies Included on PS Form 3541		0
	(3)	Free or Nominal Rate Copies Mailed at Other Classes Through the USPS (e.g., First-Class Mail)	49	0
	(4)	Free or Nominal Rate Distribution Outside the Mail *(Carriers or other means)*	100	0
e. Total Free or Nominal Rate Distribution *(Sum of 15d (1), (2), (3) and (4))*			149	0
f. Total Distribution *(Sum of 15c and 15e)* ▶			1063	0
g. Copies not Distributed *(See Instructions to Publishers #4 (page #3))* ▶			18	0
h. Total *(Sum of 15f and g)*			1081	0
i. Percent Paid *(15c divided by 15f times 100)* ▶			86%	

* If you are claiming electronic copies, go to line 16 on page 3. If you are not claiming electronic copies, skip to line 17 on page 3.

PS Form **3526,** July 2014 *(Page 2 of 4)*

Statement of Ownership, Management, and Circulation (All Periodicals Publications Except Requester Publications)

UNITED STATES POSTAL SERVICE®

16. Electronic Copy Circulation	Average No. Copies Each Issue During Preceding 12 Months	No. Copies of Single Issue Published Nearest to Filing Date
a. Paid Electronic Copies ▶		
b. Total Paid Print Copies (Line 15c) + Paid Electronic Copies (Line 16a) ▶	914	0
c. Total Print Distribution (Line 15f) + Paid Electronic Copies (Line 16a) ▶	1063	0
d. Percent Paid (Both Print & Electronic Copies) (16b divided by 16c × 100) ▶	86%	

☑ **I certify that 50% of all my distributed copies (electronic and print) are paid above a nominal price.**

17. Publication of Statement of Ownership

☑ If the publication is a general publication, publication of this statement is required. Will be printed in the 10/1/21 issue of this publication. ☐ Publication not required.

18. Signature and Title of Editor, Publisher, Business Manager, or Owner	Date
Scott Besler, Editor	09/20/2021

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

INSTITUTE SPONSOR GUIDE

AFFILIATED HEALTHCARE
Management Group, LLC

Affiliated Healthcare Management Group, LLC is a privately owned and operated healthcare revenue cycle management & consulting company. Affiliated Healthcare provides unsurpassed and unique receivables management solutions. Our philosophy has established a national presence with a regional approach that has forged into strategic partnerships with each of our clients. This allows us to build a tailor-made program to meet our clients' revenue cycle needs — while ensuring that customer service is our #1 priority — utilizing; Best People, Best Practices & Best Technology.

Best People | Best Practice | Best Technology

856-330-8207
info@affiliatedhmg.com • www.affiliatedhmg.com

Arcadia is Honored to support the New Jersey and Metro Philadelphia HFMA Chapters 45th Annual Institute

ARCADIA ANNUITY HEALTH

Looking forward to seeing everyone!

Hstanisci@Annuityhealth.com

INSTITUTE SPONSOR GUIDE

INSTITUTE SPONSOR GUIDE

INSTITUTE SPONSOR GUIDE

INSTITUTE SPONSOR GUIDE

INSTITUTE SPONSOR GUIDE

INSTITUTE SPONSOR GUIDE

INSTITUTE SPONSOR GUIDE

Thank You To Our 2021 Sponsors

AERGO SOLUTIONS

AFFILIATED HEALTHCARE
Management Group, LLC

Thank You To Our 2021 Sponsors

AmeriHealth NEW JERSEY

carepayment®

ASPIRION

CBIZ®

ARCADIA ANNUITY HEALTH

ARMC Financial Services, LLC
A REVCO MANAGEMENT COMPANY

CERTIFIED ACCOUNTS RECEIVABLE SPECIALISTS

BESLER
Smart about revenue.
Tenacious about results.

cloudmed™

CommerceHealthcare®

Thank You To Our 2021 Sponsors

CRONIS HEALTH

HRSI
Healthcare Receivable Specialists Inc.

enablecomp
complex claims revenue solutions

SMARTWorks Solution™
Powered by Jzanus

Financial Recoveries
Accounts Receivable Solutions & Management

McKAY CONSULTING

MedFinancial

From Healthcare CFO Jane Kaye
HCFA
HealthCare Finance Advisors
C-Suite Expertise When You Need It

MED·METRIX

MOSSADAMS

HLS | Healthcare Legal Solutions, LLC

HELP Financial
Patient Financing Solutions

PANACEA®
A BESLER Company

PennCredit
Service • Integrity • Results

Thank You To Our 2021 Sponsors

pfconcepts

strata

pwc

Teamwrks
Powered by RVHS

PYRAMID
ANALYTICS

United Healthcare®

QAR
Quality Asset Recovery,LLC

vereco
healthcare solutions

REVECORE

vitalware®
by HealthCatalyst®

salud
revenue partners

withum
ADVISORY TAX AUDIT

SAVISTA

Xtend
Healthcare

LOOKING FOR EXTRA CASH?

LOOK NO FURTHER...

Denials continue to be a problem for hospitals. The Advisory Board's revenue cycle benchmarks revealed the average 350-bed hospital saw denial write-offs increase from $3.9 million in 2011 to $7 million last year. ***There's your extra cash!*** ARMC has years of experience in appealing and collecting denials - inpatient, outpatient, clinical and administrative. Our technology, industry knowledge and professional negotiation skills bring results. Over the last several years we have collected over $120 million for our hospital and physician group clients. That money might have been written off and lost forever. Instead it went right to our clients' bottom line. ***Just saying...***

ARMC Financial Services, LLC
A REVCO MANAGEMENT COMPANY

REVCO SOLUTIONS™

Joe Hoban • 484-639-1961 • joe.hoban@revcosolutions.com • RevcoSolutions.com