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

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The President's View . . .

Brian Herdman

Dear Colleagues,

We return again to the Annual Institute to network and learn, now for the 46th time.

This year's annual institute will showcase the expertise and creativity of our peers in healthcare financial management. As we emerge from the pandemic, margins and financial sustainability will be under pressure; however, the ideas and solutions we walk away with from conferences like this Institute will make a difference in how our organizations meet their goals.

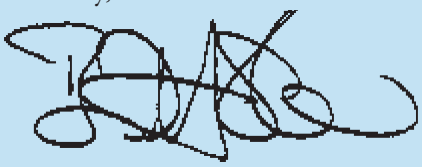
This Institute Committee has done a marvelous job in selecting a broad range of speakers and planning social functions for our attendees to mingle and network. Please join us Thursday morning to celebrate the achievements of our members at the start of the general session. Attendees can earn up to 15 CPEs (be sure to sign-in!) this year at sessions of all sorts:

- Keep up with Michael McLafferty's industry update that kicks us off Wednesday afternoon
- Learn from keynote speaker Ron Hirsch's cautionary remarks on the dangers of benchmarks
- Gain perspectives on financial sustainability with our closing CFO panel with Gail Kosyla (soon to be at Yale New Haven Health), Garrick Stoldt (St. Peter's University Hospital), and Herb White (Hunterdon Medical Center)
- Continue your personal development and listen as Katrina Campbell, Chief Ethics and Compliance Officer at Relief International (and former Assistant Professor at Rutgers University) offering tips on managing conflict in the context of diversity, ethnicity, and inclusion. Hear from Reggie Hodges on how he married passion to purpose in his life and transitioned from the NFL to the business world.
- Learn from others as they wade through the critical staffing shortages: EY will show in the Thursday general session ways health systems can get ahead on the race for talent and on Friday we will convene a workforce panel with Nick Barcellona (Temple University Health System) and Jessica Shure (Lehigh Valley Health Network).

Education and networking will always be core to our mission to serve our membership, and I look forward to ongoing back-to-business approaches as seen throughout the State. Thank you to those joining our conference calls, zooms, and meetings – I believe that the wealth of knowledge our members share with each other will be crucial to reacting to ongoing threats to sustainability. If you haven't yet joined us, I hope you will take another look at the committees and working groups in the Chapter, and share your expertise with us as a member of HFMA.

Our Institute is just one of the many ways you can grow your knowledge and network of experts to call upon. Learning is a year-round effort, and I'm proud that our Chapter is continuing to keep our membership informed on the latest in our industry.

Sincerely,



Brian Herdman

From The Editor . . .

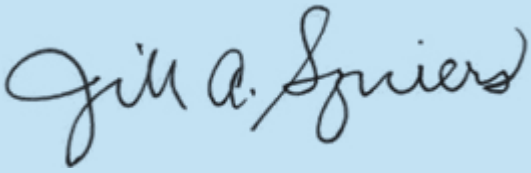
Jill Squiers

Welcome to the 46th Annual Institute edition of Focus! As I peruse the lineup of speakers for this year's annual meeting, I'm reminded of the breadth of roles that we collectively call "healthcare finance" among our members and supporters, as well as the volunteers in leadership positions in the Chapter. Our Chapter's thought leaders include individuals involved in human resources, clinical, pharmacy, information technology and privacy, contracting, and health insurance in addition to hospital roles typically associated with "finance." In other words, NJHFMA offers something for everyone! You'll find within these pages robust content from our conference speakers that reflect the broad knowledge and expertise that we're proud to bring to our networking and education, as well as this annual event.

Thank you to the many contributors who provide us with this important and timely information. Among the articles, our authors address:

Workforce management and retirement goals
Fraud and abuse investigations, especially in response to COVID-19
Year three of the pandemic and how the healthcare industry responded
Revenue management and how to measure financial success, risk and sustainability
Everyday worries like decision making, business continuity and Medicare cost reports
Out of network payment requirements and how the rules impact patient engagement & financial assistance.

Those of us who regularly attend the Annual Institute are already aware of the value that the connections made at this bring to our everyday lives, whether we are early in our careers, now enjoying retirement or in-between jobs and looking for a change in direction. NJHFMA continues to be a trusted source for information you can use, and although this edition of Focus brings it right to your fingertips, we look forward to seeing you at the Institute so you can hear it delivered by the authors themselves!



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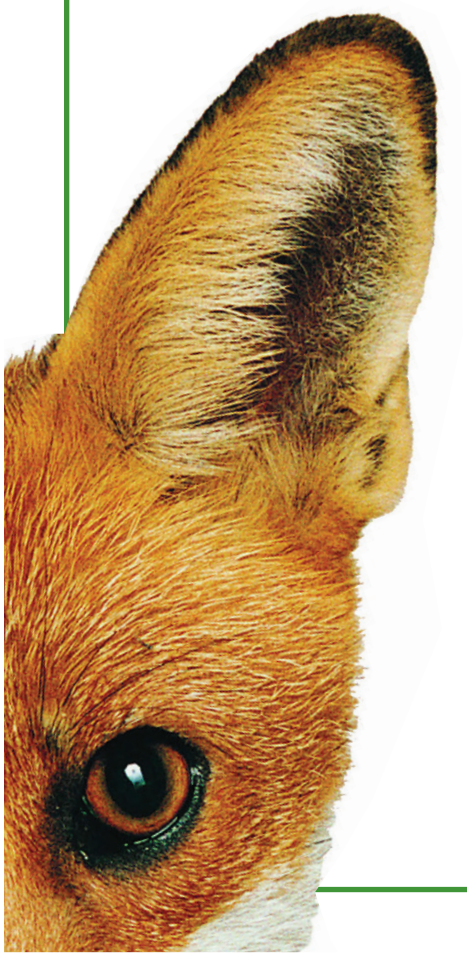

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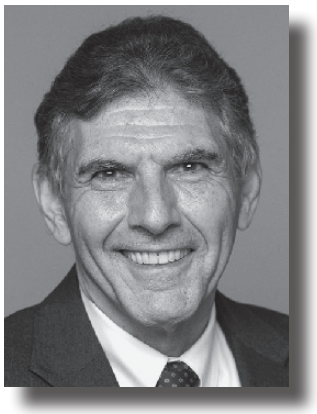
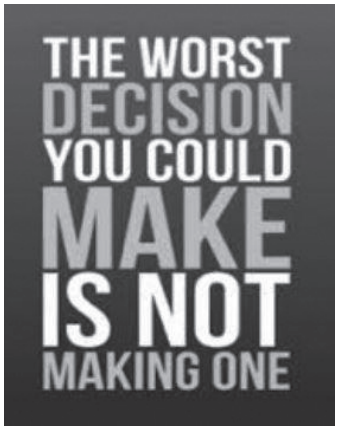
The Analytics of Better Decisions



John Nettuno

by John Nettuno



Whether deciding between pleasurable and painful options, decisions are a part of life. There is no way to avoid them.

There are prizes for making good decisions. Sometimes its money, sometimes fame, and sometimes your life.

In the financial world, gains and losses are the way we rate the consequences of a decision. You must have a personal stake in the outcome of a decision. Without this, there is no compelling motivation to do the job well.

Analytics and statistical analysis are useful to increase your odds of success. This is what differentiates them from reporting.

Our goal is to help finance professionals improve their understanding of decision-making skills by using these tools to understand the probabilities of success for specific decisions.

The objectives are to teach these professionals to become knowledgeable about decision-making, what the chances of success are in choosing decision paths, and what tools are available to help. With this understanding, managers can function more efficiently and effectively.

In order to make better decisions, one must have some understanding of probabilities. If you look at the most successful companies like Apple, Tesla, and Amazon, you will notice how analytics plays a strategic place in their operations. They always suggest sales and service options for customers based on previous actions.

Making decisions with skill requires knowledge. Either you use mathematical principles and know the odds of success or, if it is a one-time event, you find an expert who understands the objectives and has a record of accomplishment with proven successes. These are the time-tested paths to success.

These different approaches are referred as frequentist and Bayesian. Mathematicians argue frequently which is better. One is more mathematical; the other takes into account additional variables and is more experience driven.

Decision Methodologies

It has been said that life can only be understood backwards, but unfortunately, it must be lived forwards. Probability goes both ways. It allows you to look at a view of the past and allows you understand the chances of success for different decision paths.

Using analytics in this way is complex. It is mathematical and takes skill to do well.

I believe that it is well worth the effort.

You always want to understand the odds of success when moving forward with anything. You cannot get away from the concept of probability.

For example, if you ask most people what are the odds of a coin toss? Most everyone will say 50-50!

Everyone knows that a coin only has two ways to land, heads or tails, and they believe there is no preference for one side or another. Therefore, each possible outcome (heads or tails) must have a probability of 0.5 or 50%. That is the only way the sum can equal 100%

No one disagrees with that, whatever their definition of probability!

However, most people are surprised when they are informed that an ordinary one-cent piece or nickel spun on a table is more likely to come down on one side or the other. It's tails for the penny and heads for a nickel.

How can that be? You might say that does not make sense.

Yet, this is true because there is a weight difference between both sides of the coins. For the penny, the Lincoln's head is on one side of the coin and the Lincoln Memorial is on the other side. That difference matters while the coin is spinning.

It is important to remember that decision-making is usually about single events. A coin toss is a single event.

World Series games, sports events, horse races are single

events. Actually most decisions in business are a single event. Once these decisions are made, you cannot just get another try.

Single events are scored as a fraction or percentage. The numerator is the number of successful outcomes and the denominator is the total possible number of outcomes. The fraction can be turned into a probability percent.

For example, a six-sided die with the numbers 1 to 6, has a 1/6 or 16.6% chance of landing on any individual number.

The probabilities of sporting events like baseball or football game outcomes, horse races or business decisions are less exacting. These are based on an expert's opinion of what is a likely outcome. It is very interesting to note that an analysis of the way horse races actually come up show that the predictions of experts is accurate.

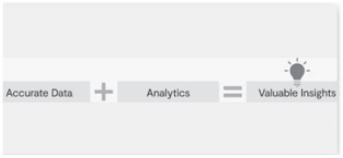
Las Vegas odds makers are also specialists. They understand numbers, but they are experts in the games they handicap.

Finance Departments make decisions all the time. Hiring, purchasing, making acceptable contact terms are just a few decisions that come to mind. When you need to make an important decision, it is important to understand the odds of success. This is why you need experts.

Not only is it a good idea to request the services of a mathematician or an expert, it important to get a good one!

Your business success could depend on it.

Best Practices



Facts and metrics help us get to better decisions. Let us discuss getting this data.

Try when possible to get the true source for data. Data changes when it is not from the original source because data elements have mathematical relationships to each other. For instance, you only have one mother, but can have multiple grandparents. The relationships, called entity relationships, are the basics for the data behind most computer applications.

When data is sourced from places other than the original source, it risks losing the relationships it has to the other data collected with it.

This is important when aggregating data and drawing conclusions. For instance, a shopping list may be for a particular meal, and the items contained may be part of the meal. When looked together, the data makes sense. However, if looked at individually or in a different context, the data could lead you to different conclusions.

According to Forbes magazine, data is the most **ignored** and valuable asset.

A best practice for data is to analyze it from its source. This is where it makes the most sense.

When analytical data is stored in a database, it is called a data lake or data warehouse. The best way to gather this data is using a direct data connection to the source data. This provides access to the latest, most accurate data.

For security of sensitive or patient health information (PHI), encryption should be employed in both storage and transit with strict controls on who has access. Role based permissions are used to provide the data to the right audience.

It is important to note that data transferred in text files is the least secure. It is also prone to errors because it is easy to corrupt relationships. There are no logs or restrictions on who is requesting it or who is receiving it, even if encrypted.

Data in databases contains logs, which can tell you if the information is changed and who is requesting it. These logs can give you a high degree of security as data base tables always log access and changes.

Security

Because data is so valuable, security should always be a top concern. A quick overview of security includes the following considerations:

- **Confidentiality:** Confidentiality in this context means that the data is only available to authorized parties using password management and role based permissions. When information is confidential, it means that other parties have not compromised it, and the data is not disclosed to those who should not have access to it. A breach of confidentiality may take place through different means, for instance, hacking or social engineering.
- **Integrity:** Data integrity refers to the certainty that the data is not tampered with or degraded during or after submission. Encryption is used to ensure this. It is the certainty that the data has not been subject to unauthorized modification, either intentional or unintentional.
- **Availability:** This means that the information is available to authorized users when needed and logs provide an audit trail. For a system to demonstrate availability, it must have properly functioning computing systems, security controls and communication channels. Systems defined as critical (power generation, medical equipment, safety systems) often have extreme requirements related to availability. These systems must be resilient against cyber threats, power outages, hardware failures and other events that might affect the system availability.

All of these considerations must be dealt with to make sure data is secure. Mistakes here can be very costly.

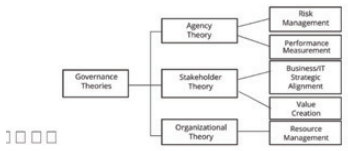
I will be covering data security more fully in my next article. Stay tuned!

Data Governance

A data governance framework is the collection of rules, processes, and role delegations that ensure privacy and compliance in an organization's enterprise data management.

It is the management of data throughout its life cycle

Every organization is guided by certain business drivers — key factors or processes that are critical to the continued success of the business.

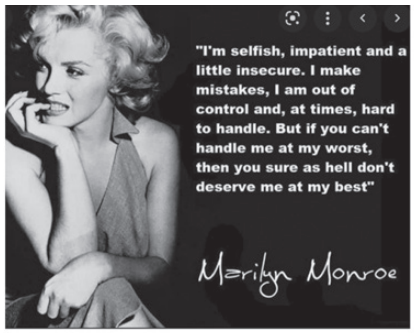


There are multiple areas to the data governance framework:

- Business Process Management – this includes how the data is used and who is responsible for the various steps of gathering and analyzing the data.
- Capability – Can we measure it effectively? There should be policies about definitions and quality.
- Compliance – Meeting the standards of all government regulations including those for security for sensitive information.
- Organizational Value – What is its value to the organization? Analytics should provide an appropriate assessment of risks to future decisions and should show real value.
- Scalability – What are the business policies about getting maximum value from data? How do we increase the value of what we have already learned?

Common Mistakes

There are common mistakes made with data collection and here are some simple rules to avoid them.



When it comes to analytics, practitioners have a tendency to overcomplicate the solutions.

It is important to understand how to best use what systems you already have and how best to use them.

Transaction systems are distinct entities and do a particular job like EMR, HR, billing, and inventory. They usually operate in real time, share information with other systems, and generate reports about the data they contain. *They are designed to handle a specific job*, but not to predict future outcomes. They are designed for a specific set of tasks

Transaction systems aggregate data well and provide pictures of what happened. They should provide a picture of what happened in the past.

Analytical systems can read data from multiple transaction systems and draw conclusions from them. By combining data with multiple sources, statistical algorithms can analyze and predict possible future outcomes. These are forward looking systems.

Properly designed, both transactional and analytical systems can provide summary and detail data. Design choices effect the accuracy, timeliness, and effectiveness of the information provided. With some overlap, the difference is that one system provides a better view of the past; the other can gives you a better future by helping you make better decisions.

Be strategic

What are your goals? Cost, quality, and time are three factors that factors that affect all decisions. It is sometimes more efficient to build a single good data model that includes multiple views than to build multiple ad hoc reports. Cost, timeliness, and goals should determine which approach is best.

Use a modeling strategy that encompasses the concepts mentioned in this article. Any methodology must be clear and concise before it can be managed.

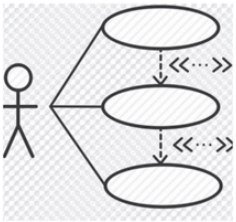
Remember that you can only manage what measure. Experience counts when planning and it is the best teacher.

Start small with specific goals and objectives. Always plan to scale upward to maximize your investment.

Analytics requires multiple skillsets using technical, managerial, and communication skills. The chances of success can be increased by studying successful use cases, and learning from the mistakes of others.

Complexity is your enemy. As Richard Branson has said, "Any fool can make something complicated."

Use Cases Examples



Typical analytical decision support endeavors affect operations, quality of service, and profitability. Measuring, automating and improving these areas are good goals. Some areas in hospitals I like to address are:

- Proactive denials reduction. Collecting revenue for services provided and reducing the percentage of denials write offs is extremely important.
- Insurance contact compliance reporting – Providing guidance for contact negotiation and care managers. This should be part of denial reduction.
- Physician capacity booking to improve productivity. This is basic workforce control. Determining improvement here can be tricky because there are many variables.
- Quantity Initiatives to measure standard hospital quality of service. Improving services requires decisions based on future trends.

- Automating and proactively measuring local and federal government reporting statistics. Getting ahead of the curve here can help you stand out from competition.

These are many use cases, but automating and improving them requires making many decisions. I hope I have provided some concepts and methodologies to make the path a little easier.

It was David Runyon, the famous prohibition newspaper reporter, who said, "The race is not only to the swift, nor the battle to the strong, but that's the way to bet".

About the author

John Nettuno is the Enterprise Analytics Manager at St. Joseph's Health. John's goals are to help clients maintain, secure and understand their data in order to optimize their revenue, operations, and margins.

He has built three secure data warehouses in the last ten years, and trained analysts, developers, and business managers how to properly model, secure, display and restore data to achieve strategic goals.

John welcomes all comments and may be reached at nettunoj@sjhmc.org.

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Pandemic Year 3: How is the US Doing?

John Dalton

by John J. Dalton, FHFMA

Two and a half years after the World Health Organization's China Country Office was informed of cases of pneumonia of unknown cause detected in Wuhan City, the worst global pandemic in more than a century continues to rage. How is the US doing? The short answer – not well enough. Except for a six-month period in 2021, America's COVID-19 fatality rate per 100,000 population has consistently ranked in the bottom quartile of the Organization of Economic Cooperation and Development's 38 member nations. At June 30, 2022, the US ranked 31st of 38, trailed only by seven former Soviet satellite states (Poland, Slovenia, Latvia, Lithuania, the Czech Republic, the Slovak Republic and Hungary, see Table 1).

Conversely, the four Pacific Rim countries (Australia, Japan, New Zealand and South Korea) have consistently ranked in the top five and four of the five Scandanavian countries (Denmark, Finland, Iceland and Norway) have ranked in the top ten. Our neighbor to the north, Canada, has also been a consistent "Top Ten" performer.

How did the US reach such a sorry state despite having the world's best-equipped hospitals and most thoroughly trained physicians? This article will focus on the two-year period from June 30, 2020 through June 30, 2022, and compare US performance with Canada, the OECD average and four different grouping of OECD member nations:

- Four Pacific Rim countries,
- Five Scandanavian countries,
- Members of the G-7, the world's advanced economies, and
- Five former Soviet satellite states.

The article then will briefly look at some of the underlying reasons why the US has underperformed compared with its peers in the OECD.

Why focus on the time period from June 30, 2020 forward? By mid-year 2020, the world had a fairly good idea of the nature and course of SARS-Cov-2. During March and April, Milan, Madrid and the Northeastern US had become the global epicenters of the pandemic, with providers overwhelmed by the outbreak, dealing with shortages of personal protective equipment (PPE) and ventilators, limited testing capabilities and learning on the fly about how best to treat the novel coronavirus. By mid-year, the pandemic continued to rage, but research on vaccines to prevent COVID-19 was well underway, testing and monitoring had been beefed up and airborne transmission had been identified as the dominant route for COVID-19 spread.[1]

Experts credit the success of the four Pacific Rim countries in combating COVID-19 to several factors (see Chart 1). Perhaps the most important is their knowledge gained from the 2002-03 SARS outbreak. For example, South Korea and the US both confirmed their first COVID-19 cases on January 21, 2020. However, South Korea moved quickly to intervene fast before it became a crisis and immediately ramped up testing, implemented contact tracing, isolation and surveillance and enlisted the public's help.[1] New Zealand actually eliminated the novel coronavirus. Border closures and a strict lockdown in March 2020 got rid of the disease and the country went 102 days without community spread.[3]

Australia, which has a similar demographic profile to the US, restricted travel and personal interaction until vaccines were widely available, then maximized vaccine uptake before gradually opening up the country again.[4] If the US had the same COVID death rate as Australia, about 900,000 lives would have been saved. The key lifesaving trait that Australians displayed: trust in science and institutions, but especially in one another. A belief that others would do what was right, not just for the individual but for the community, saved lives.

Japan's COVID death rate is the lowest among the world's wealthiest nations. With no lockdowns or mask and vaccination mandates, how did Japan do it? Peer pressure along with a nationalized health care system and severe border controls are major factors.[5] The practice of keeping in line with peers is inculcated in schoolchildren, who wear uniforms in most public schools and are shamed into following institutional expectations. Children are taught to act for the collective benefit. The public put pragmatism over politics in

Table 1. Confirmed Cases and Fatality Rates, OECD Countries as of 6/30/2022

Rank	Confirmed Cases (1)	Fatalities (1)	Fatality Rate (%)	38 OECD Countries	Population (2)	Cases per 100,000	Fatalities per 100,000
1	9,293,629	31,263	0.3%	Japan	125,905,043	7,381.5	24.83
2	1,344,275	1,467	0.1%	New Zealand	4,879,896	27,547.2	30.06
3	8,130,927	9,897	0.1%	Australia	25,910,156	31,381.2	38.20
4	193,987	153	0.1%	Iceland	344,504	56,309.1	44.41
5	18,359,341	24,547	0.1%	South Korea	51,334,293	35,764.3	47.82
6	1,446,564	3,337	0.2%	Norway	5,843,535	24,754.9	57.11
7	1,133,597	4,832	0.4%	Finland	5,553,421	20,412.6	87.01
8	3,948,112	41,911	1.1%	Canada	38,246,108	10,322.9	109.58
9	3,216,229	6,512	0.2%	Denmark	5,822,296	55,239.9	111.85
10	15,123,331	99,032	0.7%	Turkey	85,672,389	17,652.5	115.59
11	4,338,698	10,958	0.3%	Israel	8,854,312	49,001.0	123.76
12	8,283,818	22,992	0.3%	Netherlands	17,190,607	48,188.0	133.75
13	1,600,614	7,499	0.5%	Ireland	5,018,969	31,891.3	149.41
14	3,759,730	13,828	0.4%	Switzerland	8,741,810	43,008.6	158.18
15	904,934	8,525	0.9%	Costa Rica	5,157,718	17,545	165.29
16	28,181,161	141,105	0.5%	Germany	84,177,751	33,478.2	167.63
17	263,167	1,094	0.4%	Luxembourg	640,960	41,058.3	170.68
18	2,515,769	19,093	0.8%	Sweden	10,192,160	24,683.4	187.33
19	580,114	2,591	0.4%	Estonia	1,327,849	43,688.3	195.13
20	4,447,278	20,037	0.5%	Austria	9,082,066	48,967.7	220.62
21	31,151,971	150,530	0.5%	France	65,486,233	47,570.3	229.87
22	12,734,038	107,906	0.8%	Spain	46,781,452	27,220.3	230.66
23	5,160,861	24,121	0.5%	Portugal	10,152,912	50,831.3	237.58
24	5,986,917	325,638	5.4%	Mexico	130,926,674	4,572.7	248.72
25	22,895,869	180,920	0.8%	United Kingdom	68,411,120	33,468.1	264.46
26	6,151,354	139,970	2.3%	Colombia	51,681,176	11,902.5	270.83
27	4,225,222	31,903	0.8%	Belgium	11,663,899	36,224.8	273.52
28	18,438,877	168,294	0.9%	Italy	60,330,865	30,562.9	278.95
29	3,661,004	30,218	0.8%	Greece	10,348,049	35,378.7	292.02
30	3,979,797	58,467	1.5%	Chile	19,357,772	20,559.2	302.03
31	**87,581,054**	**1,017,467**	1.2%	**United States**	**333,865,970**	26,232.4	**304.75**
32	6,014,404	116,424	1.9%	Poland	37,785,440	15,917.3	308.12
33	1,037,714	6,651	0.6%	Slovenia	2,108,977	49,204.6	315.37
34	835,172	5,860	0.7%	Latvia	1,855,470	45,011.3	315.82
35	1,160,680	9,173	0.8%	Lithuania	2,666,316	43,531.2	344.03
36	2,550,368	20,146	0.8%	Slovak Republic	5,463,567	46,679.5	368.73
37	3,932,745	40,316	1.0%	Czech Republic	10,738,133	36,624.1	375.45
38	1,928,125	46,647	2.4%	Hungary	9,624,216	20,034.1	484.68
	336,491,447	2,951,324	0.9%	Total OECD	1,379,144,084	24,398.6	214.0

DATA SOURCES:
1. Johns Hopkins Coronavirus Resource Center
2. Organisation for Economic Co-operation and Development, World Bank

the approach to COVID. Japanese culture also depends on an ethic of public self-restraint. When the coronavirus emerged, Japanese experts quickly realized the virus was airborne and that the best way to reduce its spread was to keep people from gathering in small, unventilated spaces or having close contact with others. Businesses quickly closed and people refrained from going out.

Scandanavia

Finland has been the world's happiest country for five years running; Denmark and Norway hold all but one of the other titles.[6] Iceland ranks 4th and Sweden ranks 7th. The US has yet to crack the top ten. What's that got to do with the COVID-19 pandemic? Except for Sweden, the other four Scandanavian countries have consistently ranked in the OECD's top quartile for lowest fatality rates.

Sweden owned up to its false start.[7] Anders Tegnell, Sweden's chief epidemiologist, admitted in a radio interview that there was "quite obviously a potential for improvement in what we have done" in Sweden. Tegnell had previously been critical of other countries' strict lockdowns as unsustainable in the long run. Sweden closed schools for all children over 16 and banned gatherings of more than 50 individuals, but shops, restaurants and gyms remained open. Prime Minister Stefan Lovfen defended Sweden's approach as about right but noted that it had failed to protect care homes where half of all Sweden's COVID-19 deaths had occurred.

In its 2018 report "*The Opportunity Costs of Socialism,*" President Trump's advisers trashed the Nordic economic model saying it reduced living standards. To the contrary, the World Economic Forum credits the region's societal model as "*the most promising*" in charting a sustainable path out of the crisis.[8] Bloomberg Economics' Johanna Jeansson points out that these small export-oriented nations had certain advantages including *"deep public coffers, a tight social security net, and a larger reliance on sectors that have been able to work from home and sell online."* With low levels of debt as a percent of GDP (Denmark and Sweden – 40%; Finland – 70%; EU average – 90%), the countries have more leeway to spend their way out of the coronavirus recession. HSBC Economist James Pomeroy said: "*If you have a very digitally savvy population, that sets you up very well going forward in terms of productivity.*"

What else might account for the success of the four Scandanavian countries in dealing with the pandemic? Some experts cite the fact that all but Sweden were led by female Prime Ministers. Early in the pandemic, Pulitzer Prize winning columnist Nicholas Kristof posed the question: "Are female leaders better at fighting a pandemic?" Kristof compiled data from 21 countries, 13 led by men and 8 led by women.[9] The COVID-19 fatality rate was 214 per million in male-led countries and 36 per million in female-led countries including Denmark, Finland, Germany, Iceland, New Zealand, Norway and Taiwan. Noting that "Virtually every country that has experienced coronavirus mortality at a rate of more than 150 per million inhabitants is male-led," Kristof attributes the difference to male "ego and bluster" and contrasts it with the low-key, inclusive and evidence-based leadership in countries led by women.

Last year, Sweden elected Social Democratic Party leader Magdalena Andersson as Prime Minister. It's fatality rate now is lower than the OECD average (see Chart 2).

The G-7 Members

The G-7 is an informal grouping of seven of the world's advanced economies: Canada, France, Germany, Italy, Japan, the United Kingdom, the United States and the European Union. Throughout the pandemic, both Canada and Japan have consistently succeeded in protecting their residents better than the other four countries and the EU's 27 member states. Others have struggled to varying degrees (see Chart 3).

Italy was hit hard early when Milan became the early global epicenter of the pandemic in February 2020.[10] With one-sixth of Italy's 60 million people, it's the most densely populated region and Italy's industrial heartland, accounting for 21% of GDP. With the country's highest percentage over 65, Lombardy has 29% of Italy's nursing homes. When Italy became the first European country to halt air travel from China on January 31, it was already too late. Doctors treating patients for pneumonia didn't know it was COVID-19 and were unprepared for patients' rapid decline in the ability to breathe. After years of budget cuts, Italy had only 8.6 ICU beds per 100,000 people, about half the OECD average of 15.9, so many PCPs were treating patients in their homes with supplemental oxygen. Testing was limited by inadequate lab capacity, so PCPs didn't know whether they or their patients were infected. PPE was in short supply and inadequate.

The region's industrial lobbying group resisted shutting down production until March 26, long after Rome's March 7 shutdown order. Lombardy's nursing homes house more than 24,000 elderly; 3,045 deaths from February 2 to April 15, 2020 were either positive for the virus or showed symptoms. A March 30 regional decree directed nursing homes to not hospitalize sick residents over 75 if they had other health problems. Some local authorities threatened loss of accreditation if the nursing homes refused to allow visitors.

Germany fared better.[11] Germany developed testing capabilities quickly and began widespread testing, catching many with few or more symptoms. Charite Hospital in Berlin developed a test mid-January, posted the formula online and laboratories throughout the country built up a stock of test kits. Germany copied South Korea's strategy of social distancing

and contact tracing. The country's robust public health system had 28,000 intensive care beds equipped with ventilators (34 per 100,000 people).

To many, the "secret sauce" in Germany's low mortality rate was the leadership of Chancellor Angela Merkel, a scientist by training, who communicated clearly, calmly and regularly throughout the crisis. Professor Hans-Georg Krausslich, head of virology at the University of Heidelberg, summed it up: "Maybe our biggest strength in Germany is the rational decision-making at the highest level of government combined with the trust the government enjoys in the population."

Former Soviet Satellite States

The initial COVID-19 surge did not have the same major effect on many of the former Soviet satellite states as on Italy, Spain, France and the UK. However, the second surge in the fall of 2020 struck Central Europe with a vengeance (see Chart 5). Previously, the Slovak Republic had the lowest fatality rate in the Western Hemisphere (0.72/100,000) thanks to a March 16 national lockdown with universal compliance. That increased twentyfold to 14.67/100,000 by November 30. Likewise, the neighboring Czech Republic experienced a fifteenfold increase from 4.71 to 77.68/100,000. COVID fatigue had already begun.

The fall and winter of 2021-22 saw fatality rates skyrocket in both countries and in Hungary. However, after imposing lockdown measures to combat the virus, Hungary's Prime Minister Viktor Orban moved to reopen society.[12] He did so despite having the second highest fatality rate in the OECD (214.7/100,000; OECD average was 119.3/100,000). The Czech Republic was highest at 246.7/100,000. Orban noted that mass vaccination is the only way to bring the suffering to an end, downplaying the death toll and the impact on the nation's struggling hospitals. The independent news media in Hungary is not permitted access to hospitals nor are health care workers allowed to speak with journalists on the record.

Hungary quickly surpassed the Czech Republic's higher fatality rate and, at June 30, 2022, had the highest fatality rate in the OECD at 464.7/100,000, more than double the OECD average of 214.0/100,000. The Czech Republic trailed Hungary with a fatality rate of 375.4/100,000. The US was at 304.7/100,000, ranking 31st of the 38 OECD member nations, trailed only by the seven former Soviet satellite states.

Why has the US underperformed its peers?

Except for a six-month period beginning in April 2021, America's per capita fatality rate has consistently ranked in the bottom quartile of the OECD. By August month-end, the US had moved up to 26th in the rankings, just behind France and Spain, but ahead of both Italy and the UK. By June 30, 2022, all four countries had moved into the third quartile (France – 21; Spain – 22; UK – 25 and Italy – 28) while the US plummeted to 31st of 38, trailed only by the seven former Soviet satellite states.

Why has the US underperformed its peers by such a wide margin? The main reasons are discussed in detail in Chapters 3 and 4 of "Healing American Healthcare: Lessons from the Pandemic".[13] The early response was hampered by former President Trump's repeated refusal to take responsibility for combating the pandemic. When the first US case was confirmed in Washington state, on January 22, 2020, he told CNBC: "We have it totally under control. It's one person coming in from China, and we have it under control. It's – going to be just fine ."[14] After the first confirmed death on February 6th, most of the messaging from the White House continued to downplay the threat. BBC News' North American reporter Anthony Zurcher cited the following mistakes[15]:

- Testing delays due to the administration's disregard of pandemic response plans and failure to staff its public health bureaucracy;
- Medical supply shortages (masks, gloves, gowns and ventilators) due both to the government's failure to maintain the stockpile and failure to move quickly when the crisis became apparent;
- Messaging "whiplash" and political squabbles, downplaying the threat during January and February; and
- Social distancing failures like the packed Florida beaches during spring break.

On a positive note, Zurcher cited the March 25th passage of the $2.2 trillion CARES Act and America's research firepower as hopeful signs for dealing with the pandemic. The May 25th announcement of Operation Warp Speed, a public-private partnership to facilitate and accelerate the development and distribution of COVID-19 vaccines, therapeutics and diagnostics is arguably the most effective response to the coronavirus undertaken by the Trump administration. By November 2020, both Moderna and Pfizer/BioNTech had safe, effective vaccines ready for FDA review.

Inaugurated the day after America's death toll surpassed 400,000, President Biden declared: *"To a nation waiting for action, let me be clear on this point: help is on the way ."*[16] His initial goal of administering 100 million vaccine doses in his first 100 days was reached on day 58, and more than 200 million doses were administered by day 100. On March 11 – the one-year anniversary of the World Health Organization's declaration of COVID-19 as a global pandemic – the $1.9 trillion American Rescue Plan Act was signed into law. Not a single Republican in the House or Senate voted for it.[17] The US climb in the OECD rankings was well underway.

Delta dawned in Spring 2021 and by summer had kicked off a third wave of infections concurrent with increasing vaccine

hesitancy in many states. That led Centers for Disease Control and Prevention (CDC) Director Dr. Rochelle Walensky to declare COVID-19 a pandemic of the unvaccinated, stating that the vaccine is so effective that "nearly every death, especially among adults, due to COVID-19, is, at this point, entirely preventable"[18]. In September 2021, Mississippi surpassed New Jersey as the state with the highest rate of COVID-19 deaths.[19] New Jersey was hit hard in the spring of 2020 at the start of the pandemic, long before vaccines were available, but along with other states in the Northeast, had worked diligently to protect their residents from COVID-19. Despite having full vaccine availability, by June 30, 2022, another seven states (Arizona, Oklahoma, Alabama, West Virginia, Tennessee, New Mexico and Arkansas) had higher COVID-19 fatality rates than New Jersey. The US began its decline in the OECD rankings.

The two year-period from June 30, 2020 to June 30, 2022 paints a sad picture of the US response to the worst global pandemic in more than a century. Charts 7 and 8 display comparative results for three Northeast states (New Jersey, New York and Massachusetts) with three Sunbelt states (Florida, Georgia and Texas). During that two-year period, the fatality rate for the three Northeast states ranged from 183-199/100,000 compared with a range of 292-334/100,000 for the three Sunbelt states. The OECD average for that period was 188/100,000.

The three Northeast states were one of the global epicenters of the pandemic during the initial outbreak. Like many of the European countries, their long-term care facilities experienced disproportionately high COVID-19 fatality rates.[20] Since then, they have performed at the OECD average while the three Sunbelt states performed on a par with the seven former Soviet satellite states.

What accounts for the significant differences? The author will leave it to future scholars to do a deeper dive, but two factors clearly account for much of the difference: vaccination rates[21] and leadership. Governors Baker, Cuomo and Murphy placed top priority on protecting their residents. In the three Northeast states, 77-80% of the population are fully vaccinated compared with 56-69% in the three Sunbelt states. Vaccination rates in the seven former Soviet satellite states range from 51-69%. Governors Abbott, DeSantis and Kemp chose to sideline science, ignoring advice from the CDC while those in the Northeast followed CDC guidance. Had the entire US adhered to CDC guidance, it's likely that America could have matched Germany's performance and nearly 500,000 lives could have been saved.

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U.S. Supreme Court Opens the Door for More Robust Challenges to Agency Authority

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Since 1984, federal courts have routinely upheld agency action under the principle of judicial deference established in the seminal case of *Chevron U.S.A. v. Natural Resources Defense Council, Inc.*[i] Commonly known as "*Chevron* deference," federal courts will uphold an agency's interpretation of the statute it administers if the language of the statute is ambiguous, and the agency's interpretation is reasonable. So, where language of a congressional statute is unclear, the agency's position on the statute's meaning will be respected even if the agency's position changes from one administration to another. This is particularly significant when the statutory language being interpreted applies to the scope of the agency's authority in the first place. Knowing the import of *Chevron* deference, federal agencies have become quite adept at identifying inartfully drafted statutory language and interpreting that language to bestow on itself enormous policy-making power.

Critics of *Chevron* deference argue that federal judges have been too quick to find an ambiguity in the face of complex and often dense statutory language and rush to defer to the agency's interpretation, secure in the knowledge that *Chevron* deference will provide cover for their interpretation. The result, they say, is confusion by the regulated public, an abdication of the Congress' responsibility to make national policy, unbridled attempts by agencies to expand their powers without explicit Congressional authorization, and a relinquishment of the court's duty to independently interpret the law.

However, this past summer the United States Supreme Court issued two administrative law decisions addressing the outer limits of agency power, *American Hospital Association v. Becerra*[ii] and *West Virginia v. Environmental Protection Agency,*[iii] opening the door for more robust challenges to agency action.

In *AHA v. Becerra*, the Court admonished the Department of Health and Human Services (HHS) for improperly lowered drug reimbursement payments to hospitals and clinics that serve low-income communities. At issue in that case was the Medicare statute which permits HHS to set the reimbursement rate for hospitals for certain outpatient prescription drugs that the hospitals provide to Medicare patients using one of two methods:

(1) if HHS has conducted a survey of hospitals' acquisition costs for prescription drugs, then HHS may set the reimbursement at the average of the hospitals' acquisition costs, or

(2) if HHS has not conducted a survey, then HHS may set reimbursement rates at the average sales price charged by manufacturers for the drugs (with certain adjustments).[iv]

Under Method 2, the statute sets "the average price" at 106% of the drug's average sales price and prohibits HHS from varying reimbursement rates for different groups of hospitals.[v]

For over a decade until 2018, HHS consistently relied on Method 2 and set reimbursement rates based on the average sales price data provided by manufacturers. As a result, each year HHS set the reimbursement rates at about 106% of each covered drug's average sales price, and HHS used the same reimbursement rates for all hospitals. However, in 2018 and 2019, despite having not conducted a survey, HHS established two separate reimbursement rates, substantially reducing the

reimbursement rates for Section 340B hospitals to 77.5% of the average sales price for each drug while at the same time maintaining the historical rate of 106% of the average sales price for non-340B hospitals. This resulted in a reduction in the reimbursement rates for 340B hospitals of about $1.6 billion annually.

The Court was asked to decide whether HHS had sufficient discretion under the language of the Medicare statute to vary the reimbursement rates for 340B hospitals despite not having conducted a survey of hospitals' acquisition costs. HHS argued that because of their special status serving low-income communities, 340B hospitals are able to buy drugs at a deep discount creating an incentive for them to overprescribe drugs or prescribe more expensive drugs if they were reimbursed the same as all other hospitals. HHS also argued that by lowering the reimbursement for 340B hospitals, Medicare beneficiaries would save money on their co-payments since co-payments are linked to reimbursement rates. However, the Court was not persuaded by these arguments and instead held that because the government did not conduct a survey of hospitals' acquisition costs (as required by the express language of the Medicare statute), HHS acted unlawfully by reducing the reimbursement rates for 340B hospitals.

Further, HHS argued that even when it does not conduct a survey of acquisition costs and is therefore required to employ Method 2 (based on price), HHS still may "adjust[t]" the average price "as necessary for purposes of" that section of the statute. Again, the Court disagreed, holding that HHS's power to increase or decrease the price is distinct from its power to set different rates for different groups of hospitals, and finding that the statutory text of Method 2 "requires the reimbursement rate to be set drug by drug, not hospital by hospital or hospital group by hospital group." Such an adjustment, the Court continued, can consist of moving the average-price number up or down, but it cannot consist of giving a single drug two different average prices for two different groups of hospitals. Finally, the Court pointed out that if it had adopted HHS's position, HHS could decline to conduct a survey, proceed under Method 2, and still do everything under Method 2 that it could do under Method 1, including varying the reimbursement rates by hospital group. In other words, HHS would never need to conduct a survey of hospital acquisition costs. This would flout Congress' elaborately constructed statute premised on HHS's surveys of hospitals' acquisition costs and directive on when HHS could vary reimbursement rates by hospital group. Consequently, the Court concluded that the statute allows HHS to set reimbursement rates based on average price and affords the agency discretion to adjust the "price" up or down but, unless HHS conducts a survey of hospitals' acquisition costs, it may not vary the reimbursement rates by hospital group.

The case was subsequently remanded and on September 28, 2022, the United States District Court for the District of Columbia entered a written decision and order vacating the prior rate and requiring HHS to pay 340B hospitals the full rate of reimbursement for the balance of 2022. HHS is still formulating a plan for reimbursing hospitals for the past shortfalls in reimbursement.

Two weeks later, the Court decided *West Virginia v. EPA*, where it was asked to decide whether a Congressional statute which authorizes the EPA to establish emissions caps at a level reflecting "the application of the best system of emission reduction [BSER] . . . adequately demonstrated" enabled EPA to devise carbon emissions caps based on a generation-shifting approach, *i.e.*, by restructuring the nation's overall mix of electricity generation, to transition from 38% to 27% coal by 2030.

The Clean Air Act authorizes the EPA to regulate power plants by setting a "standard of performance" for the emission of certain pollutants into the air.[vi] That standard may be different for new and existing plants, but in each case it must reflect the "best system of emission reduction" that the EPA has determined to be "adequately demonstrated" for the particular category.[vii] For existing plants, the states then implement that requirement by issuing rules restricting emissions from sources within their borders.

Since the passage of the Clean Air Act 50 years ago, EPA has exercised this authority by setting performance standards based on measures that would reduce pollution by causing plants to operate more cleanly. In 2015, however, EPA issued a new rule concluding that the "best system of emission reduction" for existing coal-fired power plants included a requirement that such facilities reduce their own production of electricity, or subsidize increased generation by natural gas, wind, or solar sources. The Court addressed whether this broader notion of EPA's authority is within the power granted by Congress to EPA in the Clean Air Act.

In October 2015, EPA promulgated two rules addressing carbon dioxide pollution from power plants – one for new plants under Section 111(b) and the other for existing plants under Section 111(d). Prior to 2015, EPA had used Section 111(d) only a handful of times since its enactment in 1970. The first rule established federal carbon emissions limits for new power plants of two varieties: fossil-fuel-fired electric steam generating units (mostly coal-fired) and natural-gas-fired stationary combustion turbines. The second rule was triggered by the first. Because EPA was now regulating carbon dioxide from *new* coal and gas plants, Section 111(d) required EPA to also address carbon emissions for *existing* coal and gas plants. It did so through what it called the Clean Power Plant rule.

In the Clean Power Plan rule, EPA established "final emission guidelines for states to follow in developing plans" to regulate existing power plants within their borders. To arrive

at the guideline limits, EPA identified the BSER, as it does when imposing regulations on new sources, except the BSER the EPA selected for existing coal-fired power plants was quite different from the BSER it had chosen for new sources. Using what it called "building blocks" in its BSER determination, EPA imposed standards that effected a "generation shifting from higher-emitting to lower-emitting" producers of electricity. As EPA explained, its "building block" scheme would implement a sector-wide shift in electricity production from coal to natural gas and renewables by requiring coal plants to either reduce their own production, subsidize an increase in production by cleaner sources, or both, thereby causing a shift toward wind, solar and natural gas. EPA then translated the BSER into an operational emissions limit, which enabled EPA to require anything from a little generation shift to a great deal. EPA settled on what it described as a "reasonable" amount of shift, which resulted in a projection that by 2030 coal would provide 27% of national electricity generation, down from 38% in 2014.

From these significant projected reductions in generation, EPA determined the emission performance rates that states would be required to implement, which resulted in numerical emissions ceilings so strict that no existing coal plant would have been able to achieve them without engaging in one of the generation shifting options. As the Court recognized, "[t]he point, after all, was to compel the transfer of power generating capacity from existing sources to wind and solar." In fact, EPA's own modeling concluded that the rule would entail billions of dollars in compliance costs (to be paid in the form of higher energy prices), require the retirement of dozens of coal-powered plants, and eliminate tens of thousands of jobs across various sectors. The Energy Information Administration similarly projected that the rule would cause retail electricity prices to remain persistently 10% higher in many states and would reduce GDP by at least a trillion (2009) dollars by 2040.

The Court applied what is known as the "major questions doctrine" to EPA's Clean Power Plan, stating that if Section 111 truly empowers the EPA to devise carbon emissions caps based on a generation shifting approach, Congress must clearly authorize EPA to regulate in that manner. However, Section 111's "vague statutory grant" of authority to EPA to establish emission caps at a level reflecting the "application of the [BSER] . . . adequately demonstrated" does not amount to the kind of clear authorization required for such broad, sweeping regulation. Rather, the Court declared, "[a] decision of such magnitude and consequence rests with Congress itself, or an agency acting pursuant to a clear delegation from" Congress. Accordingly, the Court determined that EPA did not have the authority to promulgate the Clean Power Plan and struck it down.

Both decisions are notable because they ignore (indeed, make no mention of) *Chevron* or the principle of *Chevron* deference, finding instead that the limits of HHS's authority in *AHA v. Becerra* was clearly defined in the Medicare statute and the scope of the extraordinary power claimed by EPA for itself was not granted by Congress in any textual provision of the Clean Air Act. The upshot of these decisions is that federal agencies must be circumspect about relying on innocuous statutory language or general "catch all" provisions to justify their actions where such language or provisions do not (and were never intended to) authorize agency action. This is particularly true for HHS's actions taken in connection with Medicare reimbursement. Hospitals should vigilantly monitor HHS's actions which adversely affect Medicare reimbursement to ensure that they are supported by clear Congressional authority rather than simply by an exploitive interpretation that aggrandizes HHS's own power.

About the Authors

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References

[i] 467 U.S. 837 (1984).

[ii] Case No. 20-1114 (decided June 15, 2022).

[iii] Case Nos. 20-1530, 20-1531, 20-1778 (decided June 30, 2022).

[iv] 42 U.S.C. §1395(l)(t)(14)(A)(iii).

[v] 42 U.S.C. §1395(l)(t)(14)(A)(iii)(II), citing, 42 U.S.C. §1395w-3a.

[vi] 42 U.S.C. §7411(a)(1).

[vii] 42 U.S.C. §7411(a)(1), (b)(1) and (d).

•Who's Who in NJ Chapter Committees•

2022-2023 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: Fatimah Muhammad – fmuhammad@saintpetersuh.com	(732) 745-8600 Ext. 8280	First Thursday of the month	Conference Call
Co-Chair: Ryan Peoples – RPeoples2@virtua.org		9:00 AM	(667) 770-146
Board Liaison: Fatimah Muhammad – fmuhammad@saintpetersuh.com	(732) 745-8600 Ext. 8280	Access Code 473803	
Communications / FOCUS			
Chair: Jill Squiers – Jill.Squiers@AmeriHealth.com		First Thursday of each month	Conference Call (667) 770-1479
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	
Board Liaison: Chair: Amina Razanica – arazanica@njha.com	(609) 275-4029	Education Committee	
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 2022			
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	((717) 908-1977
Board Liaison: Maria Facciponti – facciponti.maria@gmail.com	(973) 583-5881	Access Code: 865290	
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	Call Line (667) 770-1400	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: Marco Coello – mcoello@affiliatedhmg.com	(973) 390-0445	Second Friday of each month	Conference Call
Co-Chair: Steven Stadtmauer – sstadtmauer@csandw-llp.com	(973) 778-1771 x146	10:00 AM	(667) 770-1453
Co-Chair: Maria Facciponti – maria.facciponti@elitereceivables.com	(973) 583-5881	Access Code: 120676	
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: James OConnell – OConnellJ@ihn.org		Third Tuesday of each month	Conference Call
Co-Chair: Paul Croce – pcroce@greenbaumlaw.com	(973) 577-1806	9:00 AM	(667) 770-1419
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
Co-Chair:: Nicole Tuesday-Wright – venntuesday@revuhealthcare.com	(848)-391-0075	9:00 AM Access Code: 419677	(667) 770-1275
Board Liaison: Jonathan Besler – jbesler@besler.com	(732) 392-8238		

Ensuring top talent for healthcare providers

Tim Glowa

by Tim Glowa

Key insights for your executive team

The pressures that have recently transformed the American workforce have especially burdened healthcare workers. The healthcare industry was uniquely affected by the COVID-19 pandemic in that they were the front lines of the battle to end it.

Healthcare was seeing some distressing trends even before the pandemic:

- The supply of workers was decreasing.
- A lack of nursing programs starved the pipeline.
- An aging workforce threatened to deplete it; while the average age of the American worker is 42, the average age of the American nurse is 50.
- Workers with less training were poached by retail and fast-food businesses.
- Workers with more training were poached by life sciences companies.
- Hospitals are too dependent on traveling nursing programs.

The issue was encapsulated by Grant Thornton Healthcare Tax Services Leader Mary Torretta: "I think healthcare was probably the hardest hit industry, and we're certainly hearing it from clients. It's a time where our country needs healthcare workers, and they're not there."

Consolidations, COVID-19 and other stressors

Using our employee engagement calculation, 50% of healthcare workers are engaged, and 22% are highly engaged. Engaged employees have a behavioral connection to the company. They say good things about it to others, they go above and beyond in their daily work activities, and they want to stay working at that company. Employee engagement can drop by 10 or 20 percentage points the minute a merger is announced, and the new organization can take a year and half to bounce back. By that time, another merger is often underway. These consolidations have resulted in larger and larger healthcare systems and thus added more layers between C-suite executives making the decisions and front-line personnel providing patient care, including physicians. At its worst, the mentality becomes Us vs. Them.

In addition, massive stresses on the industry have come by way of COVID. Grant Thornton Principal in Human Capital Services Sharon Whittle emphasized this factor: "Pre-COVID, we had a shortage of clinical folks in the healthcare industry. COVID really magnified the situation. It accelerated the labor supply shortages that we knew we were going to have anyway."

While the healthcare industry is not able to accommodate remote working to a great extent, the ability to offer some remote jobs has been a boon in that it has expanded the size of the labor market. But even this ability has presented drawbacks – particularly for hospitals located in lower labor markets.

"We're seeing now that employees that were geographically limited can now work remotely at larger markets like, say, San Francisco or Miami, at higher pay," said David Tyler, national managing principal of Healthcare for Grant Thornton. "The consequence is that the pay differential that used to be a benefit for smaller market facilities, for cost savings, is now a disadvantage because they cannot attract even local workers to these positions."

Workers face long hours, difficult working conditions and devastating patient losses, even by healthcare standards. In their private lives, many healthcare workers are also caregivers, sandwiched between debilitated parents and dependent children. Many are single parents; others carried significant debt. Recent studies show that many are suffering post-traumatic stress disorder symptoms more commonly associated with veterans returning from war.

The crisis is most acute in nursing, with an estimated 1.2 million nurses are needed to replace those leaving this year, in a field where the average age is significantly higher (50) than the average worker age overall (42). Tyler said the first step in addressing this is to understand what motivates nurses to choose the profession.

"Nurses, in particular, are doing it because they really care about people," Tyler said. Making sure their job conditions are helping them however possible – through fair pay, meaningful

benefits – offers them a way to be focused on their patients and not on whether a move to a cross-town hospital is what they need.

Tim Glowa, principal of Human Capital Services at Grant Thornton, said hospitals also have to enlarge the pool of applicants and that means considering international talent. One of the few ways the government can help healthcare is to make it easier to credentialize workers who are crossing international borders to take a job. Fortunately, the people who are attracted to healthcare are naturally resilient and optimistic. And, even more fortunately, there is some reason for optimism.

Where does it hurt? Find and address the pain points

Glowa said, "The key to winning as an employer is to think like a marketer." The best practice is to survey employees and organize focus groups to determine what matters to them — including benefits — and levels of satisfaction. You can then estimate the probability that any given employee will leave your organization, and take appropriate steps to keep them.

A recent Grant Thornton study found that among healthcare workers, the top three drivers of stress are personal debt, medical issues and mental health. That's a valuable starting point to think about the benefits that make the most sense.

Consider, for example, financial coaching for younger employees, extra payments into retirement funds for older ones, meal services for busy parents and student loan relief for recent graduates. Although hospitals can't offer the option to work from home to all workers, you could offer longer shifts for fewer days. Given the importance of mental health, you can enhance your employee assistance programs and offer services beyond the traditional employee supports.

Tyler said one way to relieve the stress of understaffing is to cross-train nurses so you are better able to shift them to temporary assignments to plug staffing holes. Understaffing issues also can be addressed by selecting areas of a hospital to close for periods of time, and less profitable areas should come under some scrutiny for these adjustments. According to Tyler, "This crisis can be a catalyst to have challenging discussions about service rationalization – particularly when combined with the M&A activity."

Getting the table stakes right includes providing competitive compensation and working conditions. Are there pay equity imbalances between current and new employees? When employees do leave, make the offboarding process smooth and friendly. About 15% of employees are either referrals or later returnees; treat outgoing employees as potential incoming employees — and treat incoming employees well.

Healthcare facilities also must address their over-reliance on traveling nursing programs. Traditionally, Tyler said these nursing programs were a beneficial arrangement that enabled nurses to travel to different areas seasonally both for personal and professional reasons. But their overuse to fill labor gaps has made hospitals too dependent on them because there is such an acute need, which in many cases has been very beneficial to the traveling nurse programs, many of which are reaping unprecedented profits. Tyler said this is top-of-mind for many hospital CEOs who are trying to join efforts to refocus these programs on people over profits.

Changes must be made to the healthcare worker pipeline, too. Thinking long-term, some organizations are beginning to introduce middle school students to the possibilities of healthcare careers. Many high school students concurrently attend college and graduate with an associate degree, making obtaining an LPN or CNA license in high school a reality. A few liberal arts schools have changed their purpose and curriculum to align for the heightened demand for clinical healthcare occupations.

Ultimately, the best recruiters are current employees who serve as raving fans, whose passion to live their natural compassion finds fulfillment in your culture. They're the essential element of a workplace where people want to stay and where desirable candidates want to be.

About the author

Tim is our employee listening and human capital leader for Grant Thornton's U.S. firm. He provides prescriptive insights to help organizations make better business decisions about their most critical asset – their people. A marketing-leader-turned-HR consultant, he has deep experience with a range of analytical employee listening tools that can help organizations better understand, engage with, reward, attract and retain their employees. Tim can be reached at Tim.Glowa@us.gt.com.

Federal Government Enforcement Actions to Address PPP Loan and Healthcare-Related Pandemic Fraud Schemes Continue

Christopher D. Adams

Robert B. Hille

Rachel A. Frost

by Christopher D. Adams, Robert B. Hille & Rachel A. Frost

While over a year has passed since U.S. Attorney General Merrick B. Garland established the COVID-19 Fraud Enforcement Task Force to utilize the resources of the U.S. Department of Justice (DOJ) and partner with various governmental agencies to combat COVID-19 related fraud, we are just beginning to see how these enforcement efforts have resulted in charges with serious civil and criminal consequences. To date, the federal government has charged 1500 individuals, with 450 people convicted. In many cases, the list of DOJ investigations and prosecutions are not just limited to the misuse of PPP loans and PPP loan fraud schemes, but also aim to hold individuals accountable and to deter similar conduct by targeting healthcare-related COVID-19 fraud in general. By all indications, there is no slowdown in government enforcement actions.

Update on Prosecutions

The use of telemedicine has skyrocketed since the start of the COVID-19 pandemic. As a result, telemedicine has become another avenue for individuals, unwittingly or not, to exploit this technology in COVID-19 related fraud schemes. In response, the government has engaged in coordinated federal investigations to bring enforcement actions against alleged perpetrators.

On July 20, 2022, for example, the DOJ pressed charges against 36 defendants for $1.2 billion in healthcare fraud. Out of the $1.2 billion in alleged total losses, $1 billion derived from telemedicine fraud schemes. The action included criminal charges against, *inter alia*, telemedicine company executives, owners and executives of clinical laboratories, and medical professionals. The federal investigation targeted fraud schemes relating to "payment of illegal kickbacks and bribes by laboratory owners and operators in exchange for the referral of patients by medical professionals working with fraudulent telemedicine and digital medical technology companies." As has been the case in other fraud charges, the DOJ seized proceeds of the fraud, which in this case included $8 million in cash and luxury vehicles.

On August 9, 2022, in the U.S. District Court for the District of Idaho, several individuals were charged with, *inter alia*, bank fraud for submitting fraudulent PPP loan applications. The individuals allegedly falsified information and documents to receive over $2.4 million in PPP loan funding. Similarly, on August 19, 2022, in the District of Kansas, a Kansas chiroprac-

tor was indicted for fraudulently procuring PPP loans estimated at $145,800. The chiropractor allegedly obtained the PPP loans from two banks, and then used a third bank to cover up the proceeds. The chiropractor is now facing multiple charges, including bank fraud, money laundering, and false statements.

Most recently, on August 29, 2022, in the Middle District of Florida, a convicted felon pled guilty to a host of charges, including wire fraud and bank fraud, for his involvement in a $2.6 million COVID-19 related fraud scheme. The convicted felon had submitted false and fraudulent applications for PPP loans, in addition to Economic Injury Disaster Loan (EIDL) and Main Street Lending Program (MSLP) loans. These loan applications not only included numerous false representations related to his criminal history and number of employees, but also allegedly fake commercial lease information. Moreover, the convicted felon used the personally identifiable information – such as name, date of birth, driver license information and Social Security numbers – of individuals who were purported to work for him to submit fraudulent payroll and tax documents. The convicted felon's fraudulent scheme caused the approval of loan proceeds of approximately $2,617,447, which were then used to purchase residences, a boat, an engagement ring, stocks, and ammunition, all of which has now been forfeited to the federal government.

Additionally, charges have been brought against individuals for misappropriating the CARES Act Provider Relief Fund (PRF) monies meant to reimburse eligible medical providers for increased costs or lost revenue caused by the COVID-19 pandemic. The Centers for Medicare & Medicaid Services (CMS) continue to actively investigate these types of fraud.

Key Takeaways

Law enforcement actions are being brought more frequently and are extensive in scope. There are currently 500 individuals working on pandemic-fraud cases within several federal and local law enforcement agencies that include the offices of 21 inspectors general, the Federal Bureau of Investigations, the U.S. Department of Homeland Security, the Internal Revenue Service, and the U.S. Postal Inspection Service.

Concerning the DOJ's pursuit of PPP loan fraud prosecutions specifically, it is critical to consider that it may become challenging for the government to discern between borrowers that intended and affirmatively acted to commit fraud and those who were well-intentioned but nonetheless failed to comply with this fast-tracked federal relief program. As a result, many unwitting borrowers or participants in general may find themselves targeted in the DOJ's pursuit of fraud charges with harsh consequences if indicted and found guilty.

While a federal district court judge ultimately determines any sentencing after reviewing the U.S. sentencing guidelines and other factors, it is important to remember that these types of charges carry with them either potential or mandatory prison time. Therefore, it is critical for those business owners who received PPP funds to immediately review their compliance, mitigate any non-compliance, and address corrective measures and exposure to enforcement with the appropriate government agency.

Moreover, healthcare providers, owners and executives of medical businesses, physicians, and healthcare marketers and manufacturers should carefully track their billing practices (including billing for telemedicine), review their internal policies and procedures, and institute safeguards, if necessary, to ensure COVID-19 relief funds are not being intentionally or negligently misused.

Additionally, as it relates to healthcare-related COVID-19 fraud in general, medical professionals should be mindful of how they are utilizing telemedicine technology and referring patients to avoid allegations of being embroiled in kickback and bribery schemes. It may also be helpful for individuals to train staff and audit internal systems to ensure personnel are meeting telemedicine requirements and complying with relevant regulations.

An essential first step is obtaining knowledgeable legal counsel or other experts who can accurately assess whether there was sufficient compliance, what any potential exposure might be, and how, if necessary, to effectively address that exposure and respond to requests for information from a government enforcement agency.

About the Authors

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Transitions Into Retirement

Christy Barilotti

by Christy Barilotti, CFP

Have you been thinking about the great resignation? And now are you picturing, "what will retirement actually look like for me?" The transition into retirement isn't something that happens overnight. It's a process that takes time and thought if you want to do it well. There are also a lot of concerns and fears when considering retirement. Today we will talk about how to transition into retirement, hopefully with grace, ease, and cash flow! As a CERTIFIED FINANCIAL PLANNER™ the topic of transition through various parts of life is a daily discussion. I find that asking questions is a way to guide people into conceptualizing retirement. People will tell me an age they want to retire by, but they have no idea what it will actually look like. What does retirement mean to you? There are so many definitions of retirement. I hear stories of uncertainty and not a lot of direction:

"My friend is retired, but they are still working."

"My friend retired early and they're on this nonprofit board and they're busier now than they've ever been."

"I have a friend that is thinking about retirement, but they're not sure if they have enough money. They're going to keep working until they figure it out." When you are trying paint the picture of what retirement looks like for you, you must ask yourself some questions. The most important question is, what do you want?

Is there a certain age that you want to retire by? Is it because that's when your parents retired? Is it because you saw your aging parents or grandparents not enjoying all the years of their savings while they worked? Or is it just a goal that you always want to retire by the time you were 55?

What do you want to be doing when you retire? There are various situations of that word "retirement." In my role, it means, at what age do you want to become independently wealthy? Sometime people feel that is too strong of a statement and they don't want to say independently wealthy, for whatever reason there's a stigma. They "just save for retirement." But that's what it is: you're independently wealthy! You're living off your assets, or income that you have strategically built over your lifetime.

Start painting the picture of retirement for yourself.

Once you don't have to show up at a job, what does your day look like? Will you volunteer for a church or your local community center, or maybe a political organization? Or will you volunteer as a nonprofit board member? Or maybe you will sit on various boards getting paid for your expertise, and you're busier now than you've ever been?

Another idea is you sell your house and downsize, and you just want to spend time with your grandkids, whether that means you're the caretaker, or you're just helping your kids a few days a week. Maybe you are just the on-call babysitter, and you love it. Simple, easy life, nothing too complex. Perhaps you stay in the house that you always have been in, and you want to play golf and take up a new hobby or learn a new language. Maybe you want to go back to school?

Do you see yourself picking up and going to your ultimate destination, whether that's your mountain house or your beach house, or just somewhere in the middle of the of the city or in the country? And that's it: you want no strings attached. You don't want to have to worry that you have to pick up the grandkids every Tuesday at 2:30. And you don't want to have to show up to a board meeting at 8:00am on a Wednesday morning. You just don't want commitments. And that's great too. Right?

This is your life. This is just the picture you're painting in your mind.

A major transition could take 5-10 years to plan out. You probably want to consider some alternatives. You could consider staying at your company in a slightly different position that's not as stressful, less income, and you're still getting benefits with a 401k match. You are just slowing down without the pressure of overseeing every project. Maybe that transition then takes two years. Maybe you can consider consulting and still have a strong income but you don't need the benefits because your spouse has benefits that will cover you. . Or you stay in your same role, but buy that second home and you WFA (work from anywhere) on Fridays and Mondays. Then you take more vacation days and work a few more years that you thought so you can figure out what the next phase of life looks like.

Don't forget, if you retire in your 50s or 60s, you have another 20, 30, 40 years left to fund! This is nowhere near your grandparent's retirement plan! This is all about transitioning into the next phase of life that brings you the most joy. That transition is so important. I tell a lot of clients that are think-

ing about downsizing or moving to another state to take some time off, go spend a week in that state in an Airbnb and act like you live there. Go grocery shopping, see if you like the community, just do some basic things as opposed to having this dream in your mind that once you retire and you have the perfect house in the perfect location that everything is perfect. Reality Check: It may not be right if you don't plan for it. Transitioning into that next phase of your life is so important on so many levels because you need to start practicing as if you are in that next phase. That's why it takes us so much time to get into that next phase of life.

Another way you could consider transitioning into retirement is to press as hard as you can, make as much money as you can, head down with blinders on, spend less money, and just go into total mode of focused on retirement for two to three years. Don't spend a lot of money, try not to travel, and make sure the home is ready to be sold the year you retire. This is not a marathon; this is a full-on sprint to the finish line. A lot of people do this. It's something I usually see people in their mid to late 50s, where it's go-time as they are at the peak of their career. They are getting stock options from their publicly traded employer each year. Some will be able to sell their company that they founded. At this point they are making the most money they've ever made, but the work is stressful. Better make sure you're doing your yoga, your meditations, drinking your green smoothies, and doing everything you can to fully support your body because this is a really stressful time! If you change your mindset, it can be a lot of fun though, because the money just keeps getting deposited into your account! When you can see the light at the end of the tunnel, your mind changes. If you chose this transition, it can usually take about a year or two to fully embrace retirement because you were on a freight train that just stopped all of a sudden. You probably lost your identity over the past couple years because you've worked so much. You stop, look around and say, "I thought I wanted that house in this town, do I really want that? I don't know...".

Start to think about how you want to transition into the next phase of your life. A slow down at your current company or consult or keep your same role, WFA and work longer, or run hard and fast to the finish line. I am sure there are many other ways to transition as well!

There are also fears that come with the idea of retirement. Not a lot of people talk about these fears though. Ask yourself, what is this finish line that I am trying to get to? What is the fear behind this? Why are you working so hard? Or why is this date so important to you? And why are you saving so much? You know, that sounds funny coming from a financial planner, but sometimes I see people won't spend anything and they're saving so much, which is fine. But why? Are you afraid you're going to run out of money? Are you able to enjoy your hard work now while still working?

Does the thought come to mind that you don't know what you're going to do with yourself once you retire? Does the thought of staying home all day without an agenda and a purpose completely freak you out? That happens to so many people!

I will also state the obvious that no one wants to talk about. You've been with your spouse for 30-40 years, you've each run your own lives independently and you came together for raising the kids and family events. The date nights are far and few between. And you're saying to yourself, "hmm, how am I going to start re-dating my spouse? I have to spend every day with him or her." This could be interesting, and this could be stressful. It's getting to know your spouse all over again and sometimes that can create a challenge. I'll throw this last fear out here too, which is very scary to say the least. A lot of people won't stop working because they fear that working is their purpose in life. And they fear when they're done working, they are going to die because they've seen it happen with their friends who worked their whole life. "He had this plan and retired at 65 and died at 67." And that is a lot of people's fears, they won't say it. But that's a big fear and I get it. So hence, transitioning into retirement is so important. Getting to know yourself again, getting to know your family, again, getting to know your spouse again. Figuring out what the next 20, 30 40 years are going to look like will require you to take some time. And if you haven't done that in the past 30 years, this is not just an overnight, silent meditation weekend that you figure it out in. This isn't a spreadsheet. Those of you that know me, I love spreadsheets! Everything I do is on a spreadsheet. But transitioning into retirement isn't just a spreadsheet. It takes time to get to know yourself. Time to get to know everything that you want to do and then you start to create this roadmap of possibilities for yourself.

We didn't get into the financials of retirement today because that comes second. The first step in retiring is figuring out what it will look like. Then you must work backwards and see if your assets can support this lifestyle. That's part of the transition. There are many CERTIFIED FINANCIAL PLANNER™ professionals out there that are ready, willing, and able to help but start to put together these different goals and objectives and then they can run a financial plan to see how this can all come together. Get your paper and pencil out and start dreaming of your graceful transition into retirement.

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The No Surprises Act– Its Impact on Reimbursement and Its Interaction with State "Surprise Medical Bill" Laws

Thomas LaGreca

by Thomas LaGreca

Very few changes to the law surrounding reimbursement for medical treatment have created as much trepidation in the medical community as the Federal No Surprises Act (NSA), which became effective January 1, 2022. The New Jersey Surprise Bill Law (SBL), which took effect August 30, 2018, and the New York SBL, enacted 3 years earlier, did not create nearly as much anxiety. This is probably because most commercial insurance (CI) claims are governed by federal rather than state law, so the state SBLs were seen as having less impact on revenue. The anxiety also, though, was based on a misconception. Most providers assumed, understandably, that the federal NSA would preempt the state SBLs, and all CI claims qualifying as emergent or inadvertent out-of-network (OON) claims would be resolved in the federal forum and not the state forum, and the federal reimbursement standard, by all appearances, would be much worse than the state SBL standards. The stress being felt by the medical community was not unwarranted. There was, is, and still could be legitimate cause for concern, but, ultimately, it might not be as bad as anticipated.

When analyzing these laws, it is important to bear in mind their purpose: they seek to shield patients from large OON balance bills, when the patient is treated by an OON medical provider through no choice of the patient. Accordingly, emergency and inadvertent OON treatment are the targets of the legislation. Fair enough. All applaud this purpose. The natural follow-up question, however, is how fair to the medical community is the reimbursement regime, and its concomitant arbitration process, since the OON provider is denied the ability to bill the patient for any balance beyond the allowed amount? To ensure fairness to the medical community the arbitration process should require the carrier to make the medical provider whole, filling in the gap created by protecting the patient from a balance bill.

This article will explain which law – federal or state – applies to what claims and why. The article will also examine the relative standards of reimbursement under these laws and how the medical community has fared thus far. The article will conclude with an emphasis on what questions your revenue integrity process needs to be asking and why.

Federal Law Versus State Law

Any medical provider treating a patient on an OON basis through the ER or inadvertently must know at the outset which forum – federal or state – will resolve any payment dispute. This is necessary because the forums vary in their timelines and procedures as well as the reimbursements likely to be awarded.

Generally, the state SBLs regulate fully insured health plans typically written for small employers in that state. State SBLs also govern state-employee self-funded health plans. All other self-funded plans, which includes large-employer plans and union plans regulated under ERISA, are typically governed

by federal law. Federal-employee plans are also governed by federal law, not state law, so they too would come under the purview of the NSA. Accordingly, if a state, such as New York and New Jersey, already has its own SBL, the NSA does not preempt the laws of those states with respect to their state-regulated health plans.

In addition, the NSA applies to both federally regulated plans and state-regulated plans originating in states which have not yet passed their own SBLs. This means any OON ER claim or OON inadvertent treatment comes under the federal law whether it is otherwise a state-regulated plan or federally regulated plan from a state with no SBL of its own.

Finally, the federal law applies to claims involving out-of-state plans, where the treatment is in one state and the plan originated in another. An ER claim, for example, involving a fully insured plan written by Blue Cross Blue Shield of Texas would be resolved in the Federal IDR process, because neither New Jersey, where the treatment occurred, nor Texas, where the policy originated and was regulated, would have jurisdiction.

In short, the federal forum covers claims involving federally regulated health plans from states with their own SBLs, plus all qualifying claims from states without their own SBL, and also claims involving plans from states other than the states where treatment occurred. This makes for a complicated upfront analysis, but it is one that is critical to master because choosing the wrong forum can result in untimeliness. To assist with this, many providers investigate whether a plan is state-regulated or federally regulated before even billing the claim so that they are aware of the forum for dispute resolution immediately at receipt of the explanation of benefits (EOB) or payment. The New Jersey SBL and the federal NSA both come with 30-day deadlines for objecting to a payment - New Jersey measured in calendar days and the NSA measured in business days – so if you commence an action in the wrong forum, you will likely be shut out of the arbitration process when you get to the correct forum. Knowing the proper forum when the EOB or payment is received goes a long way toward ensuring timeliness.

Medical Denials

The SBL and NSA processes do not cover medical denials. These denials are to be pursued in the existing external appeal process. Typically, only underpayments and, to a more limited extent, administrative denials, are addressed in the SBL and NSA processes. If you are not conscious of this distinction, it is very possible you could find yourself in one or the other forum and be shut out temporarily for being in the wrong forum and/or permanently for untimeliness.

The Differences in Reimbursement Standards

Once you know the treatment is governed by an SBL or the NSA, and you recognize it is an underpayment resolvable under the relevant SBL or NSA, the final question is how will my practice or facility be reimbursed?

Typically, the states with SBLs can be divided between what I like to call "medical-provider-friendly states" and "medical-provider-unfriendly" states. For purposes of this discussion, let's shorten that to friendly and unfriendly. Several states, such as Maryland, Colorado, Michigan and Indiana, are what I call unfriendly SBL states. This means the standards of reimbursement used by the decision-making entity rely too heavily on Medicare rates and median in-network rates. These states almost indubitably are unfriendly to the medical community when it comes to SBL reimbursement. Other states, such as New York, New Jersey, Florida, Texas, Missouri, Ohio and several others, call for reimbursement that is "reasonable" or "commercially reasonable" or straight-up "usual and customary rates," what we know as UCR. These are the friendly jurisdictions, where the reimbursement standard is not tied to Medicare or in-network rates.

The NSA is a sort of hybrid between the two. This is not surprising in light of the way legislation is passed at the federal level. There is an old saying in legal circles, "The two things you never want to see made are sausage and legislation," and the NSA is a perfect example of why. For years the debate raged as to whether the reimbursement standard should be UCR-based or Medicare-based. Back and forth Congress debated, with the medical community lobbyists on one side and the insurance industry lobbyists on the other, until just after Christmas on December 27, 2020, the law was passed. The result for reimbursement (drumroll please): reimbursement is based on neither Medicare nor UCR but in reality can be based on either. Let me explain.

Broadly speaking, the reimbursement standard in the law is "reasonableness." This is the same language used in many of the state SBLs that are regarded as friendly and is the mainstay of any UCR analysis. But the federal law expressly prohibits "usual and customary charges" from the calculus. Medicare is also expressly excluded from consideration. These were obvious accommodations to each side of the debate by the parties orchestrating this messy compromise. So, where does that leave us in the federal process? We know what cannot be considered – so what can be considered?

Well, several factors – some mysterious, some vague, some questionable – can be considered. First, there is the Qualified Payment Amount or QPA, which supposed to represent the median in-network rate of the particular carrier in the geographic region where the treatment occurred. Well, many in-network rates, especially at the low end, are based on Medicare rates, so indirectly Medicare is being considered.

An additional factor is the training, experience, and quality of the practitioner or facility rendering the services. Pre-

sumably this means more reputable practitioners and facilities could be entitled to greater reimbursement, which seems reasonable.

The market share of the provider is also a factor, though how that might factor into such an analysis is unclear. Nor is it obvious why it should. Would smaller facilities be entitled to greater reimbursement or larger facilities? And if so, why?

The acuity of the patient is a factor, which is perfectly sensible, but one would think this would be in large part captured by the CPT codes billed, the modifiers, and the units charged.

The teaching status of the facility is a factor, which I assume seeks to capture additional expenses incurred by the facility as an educational institution, which seems eminently fair.

Finally, "[d]emonstrations of good faith efforts . . . to enter into network agreements" and any "contracted rates" between the parties within the previous 4 years can be considered. This would suggest that single-payor agreements and payments pursuant to "settlement" agreements could be considered, as well as payment data as long as it was not a function of charge data.

How all of this will ultimately be interpreted remains uncertain and the limited results thus far suggest it will be some time until any clear outcomes could be predicted. Results are mixed to say the least, with reimbursement ranging from very poor to very favorable. What is clear is that the vagaries in the legislation provide ample ammunition to both sides of the reimbursement issue. Only a large universe of arbitrator decisions will bring a semblance of predictability, and even that predictability will depend largely on which arbitrators hear the dispute.

Questions Hospitals Must Be Prepared to Answer

In conclusion, your revenue cycle teams must be prepared to answer the following questions:

- Does your revenue cycle process know how to distinguish effectively between a state-regulated claim and a federally regulated claim?
- Does your revenue cycle allow for you to meet the stringent timelines: 30 business days to object, 30 business days to negotiate, and then 4 business days to file the arbitration at the federal level; and 30 calendar days for each of those steps in the New Jersey state process?
- Do you realize the SBL and NSA processes replace your normal appeal process as the appropriate workflow, but not in instances of OON ER and inadvertent claim denials?
- Do you know what your reimbursement is likely to be and what the law generally entitles you to within each forum?

I hope this article helps with answering all of those questions and succeeds in at least revealing the questions you need to be asking.

About the author

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New Jersey Healthcare Financial Management Association 2021-22 Chapter Awards Listing

President's Award
John Dalton

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Alex Filipiak, CHFP
Nicole Rosen
Joseph Tafaro, CPA
Sally Cummings
Gerry Blass
Donna Heringes

Founders Merit Award - SILVER
Steven Stadtmauer, Esq.
Heather Stanisci

Founders Merit Award - GOLD
Sandra Gubbine, FHFMA, CPA
Christine Gordon

Member in a Non-Leadership Position
Christine Gordon

Health System Finance: CFO Strategy

David Grizzanti

by David Grizzanti CPA, MBA

Inflation Conundrum or Opportunity?

The stark realities facing health system leaders during this time of inflationary and recessionary hardship, are paramount. The US economy and health system have not experienced this level of inflation since the late 1970s and early 1980s. Back then, cost-based hospital revenue models (pre-DRG era) were somewhat "elastic" and could withstand the impact of high costs and labor. Not the case for today's CFO and finance leaders – and this hyperinflation will likely continue over the next four to eight quarters. Also consider that there is no "new money" coming into the US healthcare system anytime soon. We cannot expect to see Medicare or Medicaid rate adjustments offsetting inflation and, commercial rate increases, if any, will likely be well below the rate of inflation.

Escalating expenses have devasted razor-thin operating margins caused by the pandemic and this trend will accelerate due to persistent inflationary pressures residing in supply chain, labor supply, energy costs, and the imputed cost of capital. The basic supply-and-demand aspects of nearly all profitability determinants are expected to have an adverse effect on quarterly earnings throughout 2022-2023. Some economists do not predict a recovery until 2024-2025.

Where are We Now?

In 2022, top line revenue is suffering, while expenses swell at an increasing rate. Profitability and cashflow from operations may continue their descent for the ensuing 12–24 months. Fortunately, some savvy CFOs implemented strategies to bolster their balance sheets throughout the pandemic. However, a strong financial position will eventually give way to eroding profits. And if you factor in "wildcard-unknowns" such as: a new pandemic surge, geopolitical fallouts, and failed domestic policies, even the most highly-rated (i.e. Fitch, Moody's, S&P) health systems are not immune to a financial hit.

Expectedly, most experts agree it will get worse before it gets better. Inflation, labor supply, investment losses, and supply chain issues will likely worsen. This is not anecdotal, it's a nationwide phenomenon. State hospital associations and reporting organizations are sounding the alarm. In Washington state for example, during 1Q2022, hospitals lost nearly $1B due to increased operating expenses and investment losses, noting that all 52 of the state's urban hospitals and health systems reported negative margins averaging -13%.

Amid these unprecedented fiscal challenges reside the core components of your health system: patients, providers, and employees. How can you make care more affordable, accessible, and equitable for the communities you serve? What technology and innovation investments should you make, which ones should you forego? How can you best leverage existing infrastructure investments to harvest revenue and margin? What can you do to attract and retain the best talent while providing a safe, productive, and rewarding environment for clinicians, administrative, and operations professionals? What is my go-forward, true cost of capital? These questions cannot be ignored when evaluating strategies for near- and long-term sustainability.

Light at the End of the Tunnel or an Oncoming Train?

Strategies to navigate the ***Inflation Conundrum*** will vary greatly based on organizational makeup, competitive landscape, geography, and leadership's experience with developing and executing winning strategies. Plans may involve new, innovative partnerships, technology investments, service line assessments, operational efficiencies, competitive/market re-positioning, revenue harvesting, and expense cutting. Viable strategies may even involve mergers and acquisitions, as hospitals seek to generate economies of scale and gain skills to enable them to take on additional risk contracts.

Regardless of the approach, several common denominators should be considered: 1. What is the impact to your patients (i.e. engagement, health equity, access, patient-as-the-payer)? 2. What is the quantifiable near- and long-term cost benefit and effect on financial position, credit rating and liquidity? 3. Can existing investments be leveraged to accelerate or increase ROI? 4. Where can the most gain be realized with acceptable

risk levels? 5. Have you reassessed your true cost of capital in the wake of inflationary trends? 6. Do you have the right balance of staff, technology, and capital-leverage, to optimize health system performance? CFOs may have to get out of the comfort zone and take on a certain level of "measured risk" if *the juice is worth the squeeze.*

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CURAE is a proven strategic partner for health systems with over 25 years of delivering ROI. CURAE exists to empower providers to serve their communities by making care affordable and accessible for all patients. CURAE's institutional-grade, low-cost funding is frictionless for patients and staff; enabled by our fintech, consumer-centric model that interoperates within existing technology platforms. CURAE is capital market leverage that improves provider results—guaranteed.

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•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.**

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COMPLIANCE COORDINATOR
Virtua Medical Group

Can Healthcare embrace innovation and disruption to creatively address workforce shortages while ensuring productivity and quality?

Sandra Pinette

by Sandra Pinette

Even prior to 2019, the healthcare industry was facing a slew of pressures forcing providers to pivot in the delivery of certain services within their communities.

Decreased reimbursements, increased regulatory requirements, shifting payment models, aging healthcare staff and patients were taking a toll on already thin clinical and non-clinical administrative resources.

Models such as mandatory overtime and utilization of external staffing resources were seen as an interim fix. Unfortunately, many organizations discovered they were untenable long-term solutions-resulting in burn-out and unreliable staff inventory.

Healthcare, like no other industry, has been seismically shifted due to:

- COVID-19 global pandemic
- Reduction of scheduled, routine, and preventative procedures
- Increased severity of patient care
- The Great Resignation
- Cyber-security demands
- Generational workforce demographics/expectations
- Inflation

A recent poll of 1000 healthcare workers from October 2021 by the Morning Consult indicated that "since February 2020 that **30% of percent of U.S. health care workers have either lost their jobs (12 percent) or quit (18 percent), while 31 percent of those who kept them have considered leaving their employers during the pandemic."**

According to an article from the **American Hospital Association (AHA) in April 2022, there was an overall increase in per-patient labor costs of 19%.** Additionally, in a secondary article by AHA, the "Cost of Caring" it stated that **prior to the pandemic 50% of hospitals expenses were related to labor costs** associated with recruiting and retaining employed staff, benefits and incentives.

Is it time for an industry like healthcare to break long-held staffing strategies to address its anemic workforce shortages in the midst of all of it?

Optimal patient care combined with the current delivery method for both medical and non-clinical functions has never been more misaligned.

The unsustainability of the current staffing models has caused healthcare providers to think long and hard about its mission and priorities as an organization, causing many to ask fundamental questions like:

- **What's the single most important thing to focus on as a healthcare facility?**
- **Are we able to provide services in all areas of care that our patients need?**
- **How can we continue to deliver the best care to patients and stay fiscally viable?**

Many are re-evaluating the entire workforce stratosphere and seeking inspiration from other industries. Historically, many industries and their associated workers have pivoted and

created blueprints for models to deliver services and micro-economies driving meaningful change for both parties.

One of the most intriguing models to address workforce shortages, as well as the demand for alternative service delivery methods is the "gig" template. Think Uber and Instacart. These companies were trailblazers, they completely disrupted the traditional model for matching consumer services and the associated workforces to fulfill them.

Clinical short-term resources such as travel nurses, respiratory therapy and other specialty areas are not anything new.

However, the non-clinical/administrative side of healthcare has not been as quick to catch-up. The pandemic and worker expectations are now stretching the demand for working outside of the "proverbial four walls" of a traditional office setting.

During the pandemic, many opened up this option – particularly for non-clinical team members who could use technology to perform functions such as non-patient facing functions, like coding or other revenue cycle/business office functions. These team members were dependent upon remote technology to complete tasks and interact with colleagues and potentially communicate with patients.

Working remotely was put into place at an unprecedented rate for non-clinical/patient facing roles during the pandemic. This was fraught with certain drawbacks for many providers:

- Increased cyber security issues
- Unsecured PHI access
- Lack of accountability for productivity standards and quality measures
- Reduction of actionable auditing of work product

Now two years into the pandemic, healthcare, like other industries, is still recovering to reach pre-pandemic levels of services delivered and the staff needed to do so.

With record workforce shortages, rising inflation, consumer prices and workers wanting to have more control and flexibility, the gig environment can create the right balance for both providers and staff.

Gig workers can provide the additional coverage needed so that clinical services can be delivered to patients and ensure the non-clinical administrative/revenue related tasks are completed.

Financial strain resulting from overworked staff members in all areas of healthcare results not only in burn-out and more lost hours but reduction in quality and having to duplicate tasks.

The on-demand model in non-clinical/administration areas can be effective in reducing expenses, overtime, burnout, and on-going unmet workforce needs.

It also provides the flexibility and opportunity to make additional revenue when needed and sharpen skills all while not committing long-term to a particular organization. The lynchpin to successfully executing on this model is the technology to foster an environment where providers and workers can:

- Safeguard PHI
- Protect against cyber-attacks
- Deliver real-time transparency and accountability for all parties for quality and productivity
- Financial viability for all parties to thrive and drive value

The question is can healthcare providers adopt a new way of disrupting traditional staffing models in various areas of the organization? Can on-demand/gig strategies deliver the solution?

Healthcare is in the business of innovation and disruption by its mission. Why not pivot and create disruptive solutions to drive value, financial stability and ultimately deliver the care our patients and our communities need.

About the Author:

Sandra Pinette is Vice President of Sales for Kode. She has over 15 years in the healthcare revenue cycle space working with various firms servicing providers across the country. A past president of the NHVT HFMA Chapter, she's presented at multiple hfma events on to 501R, ACA/Medicaid expansion and Personal Branding at Women in Healthcare venues. Sandra can be reached at Sandra.Pinette@kodehealth.com.

Rethinking Patient Financial Engagement Under Financial Impacts and Rapidly Changing Legislation

Samantha Roberts

by Samantha Roberts

Many hospitals and health systems are still reeling from the financial strain of the COVID-19 pandemic and a turbulent regulatory landscape, causing a myriad of concerns regarding hospitals and their financial health. A recent survey of 205 CFOs and VPs from large health systems and physician groups listed the biggest issues that healthcare financial leaders face regarding the financial health of their organizations. Among their worries were labor shortages, rising costs and inflation, all exacerbated by changing federal and state legislation that aims to combat rising medical debt and increase patient protections.

Rising costs and inflation

Rising costs were the foremost concern of these hospital CFOs and revenue cycle VPs. According to data from the American Hospital Association, health systems have experienced surges relating to labor medicine, supplies, equipment, and other vital resources since the pandemic. Rising costs are illustrated with the 19.1% rise in labor expenses from 2019 to 2021, supply costs increasing 21% per patient overall, median medicine costs up 37% per patient, and intensive care unit supply costs up 32% per patient.

While rising costs may not change soon, providers can offset these costs with a patient financial engagement vendor that can offer a solution to increase earned revenue from patient collections. Vendors that offer a zero-interest, pre-bad debt patient financing solution not only save providers and revenue cycle management (RCM) departments much needed time and resources within the current landscape, but this solution also engages 100% of a provider's patients – including those who are reluctant or unable to advocate for their own financial health early in their healthcare journey and will not qualify for traditional credit programs. As providers fear rising costs, an effective zero-interest, pre-bad debt patient financing solution increases revenue for the services rendered and infuses hard-earned dollars back into hospitals and health systems.

Increasing labor shortage

Nearly every survey respondent reported a severe labor shortage in their revenue cycle management department – with some saying over half of their department's roles are vacant. A recent Becker's Hospital Review article reports an estimated 1.5 million healthcare jobs were lost in the first two months of COVID-19, and further complications from the pandemic continue to add pressure to an already strained system. The economy has helped create more new jobs; however, healthcare employment remains below pre-pandemic levels, with the number of workers down by 1.1% or 176,000 compared to February 2020, shedding light on the continued need for healthcare workers. The staffing shortage is likely to continue, as indicated by a February 2022 USA Today and Ipsos survey of more than 1,100 healthcare workers, which revealed that nearly a quarter of respondents said they would likely leave the field due to the pandemic.

In March 2022, the American Hospital Association authored a letter to the House Energy and Commerce Committee, calling the healthcare workforce shortage a "national emergency," Furthermore, the AHA projected the overall shortage of nurses to reach 1.1 million by the end of the year.

As these issues plague hospitals and health systems, CFOs and revenue cycle VPs are looking for solutions and turning towards automation and technology to fill in the labor gaps and reduce costs. The future of the revenue cycle is trending towards a self-serve, automated RCM model and leveraging comprehensive patient financial engagement platforms to fill the holes in the revenue cycle department. Providers need to find a vendor that is equipped to engage patients in all stages of the RCM cycle, including handling all patient communications regarding patient financing plans.

Federal and state legislative actions and trends

As of January 1, 2022, certain aspects of the No Surprises Act went into effect. As part of the Biden administration's focus on enforcement of the No Surprises Act, the Consumer Financial Protection Bureau (CFPB) issued a bulletin indicating that it will closely review the practices of those engaged in the collection or reporting of medical debt, will hold debt collectors accountable for failing to comply with the Fair Debt Collection Practices Act and Regulation F, and will hold consumer reporting agencies and furnishers accountable for failing to comply with the Fair Credit Reporting Act and Regulation V. The CFPB has stated that it "will use all appropriate tools to assess whether supervisory, enforcement or other action may be necessary."

As expected, most providers are finding that staying compliant with the No Surprises Act is no easy task. A Becker's Healthcare Review article revealed that compliance officers from various healthcare facilities stated that implementing policies and procedures to stay compliant with the No Surprises Act has put a strain on their resources – resources that are already burdened by lasting COVID-19 impacts, increased costs and excessive staff turnover.

In April, the Biden administration announced a plan to crack down on predatory billing practices that result in increased medical debt, including holding debt collectors "accountable for harmful practices". The Department of Health and Human Services will request data from more than 2,000 healthcare providers regarding medical bill collection practices, lawsuits against patients, third-party contracting, and debt buying practices, among others.

And to top it off, a series of legislative changes cracking down on the U.S. medical debt crisis have been proposed or implemented across the country at the state level. Some of these changes don't directly affect healthcare providers, but may significantly impact the debt collection process and any vendors that collect on behalf of providers. As of July 2022:

- 10 states (including California, Illinois, and Maine) required hospitals to provide free or discounted care to patients who meet certain income thresholds. At least 13 others have limited debt collection practices.
- In New Mexico, hospitals are prohibited from suing patients with incomes below 200% FPL, placing liens on their property, or garnishing their wages. In Nevada, debt collectors are required to provide written notice to patients at least 60 days before any collection action is taken.
- Colorado and Maryland have passed legislation that requires providers to screen patients for financial assistance and offer income-based payment plans to all eligible patients, as well as limiting collection practices. North Carolina is considering similar legislation with the recently introduced Medical Debt De-Weaponization Act.
- At least 33 states had some form of surprise billing protections, and several states have pending legislation around restricting or banning interest on patient balances owed for healthcare services.
- Other state legislation in recent years has focused on price transparency or limiting the impact of debt on people's credit scores and livelihoods.

As the self-pay, out-of-pocket medical costs crisis reaches the tipping point, there will be even more vendors in the patient financial engagement space offering patient payment and financing without the proper compliance and regulatory underpinnings. Adding to this, many vendors within the space offer deferred-interest solutions, which have continually come under legislative and public scrutiny due to their contribution of the rising medical debt crisis.

So, what should providers consider when choosing a patient financial engagement vendor? Vendors should have protocols in place to ensure that consumers are treated fairly, and that their providers aren't overburdened by risk. Patient financing solutions should have all of the appropriate compliance and regulatory mechanisms in place to protect both patients and providers.

Additionally, solutions that do not report to credit agencies, are always zero-interest for patients, and offer compassionate, income-based payment options and flexible terms will attract more patients, which in turn will generate more revenue for providers. For providers looking for long-term success in navigating the ever-changing landscape of patient financing, solutions that are truly patient-focused will help providers enhance their strong collections, increase patient satisfaction and maintain compliance in a fast changing regulatory environment.

About the author

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Current Trends in Federal and State Fraud and Abuse Investigations

Jack Wenik

by Jack Wenik

In my article about fraud and abuse investigations published in the Fall 2021 issue of *Garden State Focus Magazine*, I noted that we were at the "tail-end of the pandemic related to COVID-19." Unfortunately, more than a year later, at least as far as government bureaucrats are concerned, COVID-19 is still with us. On July 15, 2022, Secretary of Health and Human Services Xavier Becerra signed an extension of the "public health emergency" ("PHE") related to COVID-19.[1] Thus, the PHE is going to be with us at least through October 13, 2022.[2] This, coupled with the continued implementation of dramatically altered policies by the Biden Administration, has profound implications for fraud and abuse investigations.

Potential Beneficiary Fraud

As I noted in my previous *Garden Focus Magazine* article, the Biden Administration has reversed the trend toward "Work for Medicaid" programs, rescinding their implementation. In a stroke this eliminated the potential of investigating large numbers of Medicaid beneficiaries for potential fraud and abuse in participating in the program. However, I may have spoken too soon in this regard. One state, Georgia, has since sued the federal government, arguing that CMS's rescinding its approval of Georgia's Work for Medicaid program was a breach of contract in which the federal government has "tried to foist on Georgia unconditional Medicaid expansion."[3]

Regardless of how Georgia's litigation turns out, it is reasonably certain that state authorities will soon be focusing on Medicaid beneficiary fraud. Many states (New Jersey included), when coping with the pandemic, eased the way for beneficiaries to apply for and receive Medicaid benefits. For example, New Jersey permitted Presumptive Eligibility applications to be submitted via telephone.[4] This easing of applying for and receiving benefits was coupled with a moratorium, imposed for the duration of the PHE by CMS, of redeterminations of Medicaid eligibility and dis-enrollments.[5] Essentially, for the duration of the PHE, states have been prohibited from purging the Medicaid rolls of those who are either ineligible or who have been fraudulently receiving benefits.

The result of this "continuous enrollment" requirement is that there are now a record 85 million individuals receiving Medicaid benefits.[6] Of course, while Medicaid has expanded in most states to cover able-bodied individuals, it is still a program designed to assist the indigent, with eligibility limited based on income and assets. Coupled with the current economic climate of near record low unemployment levels, it goes without saying that the number of improperly enrolled individuals are in the millions, a significant number of which are the result of outright fraud.

It is simply unsustainable to continue Medicaid expenditures at the current level. Moreover, public sentiment is growing that something must be done about this issue.[7] Eventually the PHE will expire and states can be expected to once again investigate beneficiaries who are not entitled to benefits.

The implications for providers are clear. They will need to again verify Medicaid eligibility of clients/patients. Moreover, turning a blind eye to obvious Medicaid fraud (e.g., a patient driving up to a clinic in a luxury automobile) may expose them to being accused of aiding and abetting a fraud. While provider fraud and abuse will always be paramount for state and federal investigators, the sheer scale of beneficiary fraud should make itself felt in coming months.

Telehealth Fraud

I also noted in my Fall 2021 *Garden Focus Magazine* article that, as a means of coping with the pandemic, telehealth had become more mainstream and recognized for reimbursement

by both Medicare and Medicaid. Given the increasing level of reimbursements for telehealth, it has become a focus of state and federal fraud and abuse investigations. Some recent developments have reaffirmed this trend.

On July 20, 2022, the Office of Inspector General, Department of Health and Human Services, issued a Special Fraud Alert entitled *OIG Alerts Practitioners to Exercise Caution When Entering Into Arrangements with Purported Telemedicine Companies.*[8] The Alert calls attention to those schemes in which a practitioner receives financial inducements/payments to prescribe drugs, order tests, or order durable medical equipment for patients with whom the practitioner has no prior relationship and/or has not properly examined. These frauds are especially prevalent in the genetic testing space where reimbursements are high and the benefits of such testing are limited to very special circumstances. The Department of Justice has had an ongoing initiative to prosecute such arrangements in "Operation Double Helix."

The OIG's Alert serves merely to reinforce the sound advice that providers should conduct extensive due diligence before doing business with any telemedicine company. Telemedicine services themselves should be treated the same as in-person services in that they need to be properly documented and scrutinized for medical necessity. Telehealth is now an accepted aspect of medical care which will be a permanent part of the health care landscape beyond the pandemic. Providers should thus have detailed guidelines and policies in place regarding same, especially the appropriate coding of such services and the justification of the medical necessity of telehealth services.

At the other end of the spectrum, telehealth is now so much a part of the mainstream that providers need to be concerned that they have properly provided access to same. On July 29, 2022, the U.S. Department of Health & Human Services, Office for Civil Rights and the U.S. Department of Justice, Civil Rights Division, jointly issued: *Guidance on Nondiscrimination in Telehealth: Federal Protections to Ensure Accessibility to People with Disabilities and Limited English Proficient Persons.*[9] Practitioners need to familiarize themselves with requirements of this Guidance as a single complaint by a disaffected individual can trigger a federal investigation.

In essence, the Guidance requires that providers which offer telehealth services must, at their own expense, provide enhancements so that various disadvantaged populations can take advantage of them. This can include such items/efforts as: providing additional time to persons of limited intellectual ability, a sign language interpreter to deaf patients, audio descriptions/screen-reader compatibility for the blind, and interpreters for non-English speakers. This list is by no means definitive. Moreover, the common theme is that these accommodations must be made at no cost to the patient.

The lesson here is that if a provider is going to provide telehealth services, they need to factor into their cost calculations the expense of providing enhancements to make the service accessible to all. Given the Biden Administration's emphasis on civil rights enforcement, it is not beyond the realm of possibility to anticipate undercover investigations in this space. Providers who ignore this recent DOJ/HHS Guidance do so at their peril.

COVID-19 Fraud Investigations

Fraud and abuse enforcement related to COVID-19 is such a large portion of the Department of Justice's efforts that there is a Director of COVID-19 Fraud Enforcement, Associate Deputy Attorney General Kevin Chambers. According to Mr. Chambers, the Department of Justice (including US Attorneys Offices) has charged 1,481 defendants in pandemic related fraud matters involving $1.1 billion in losses.[10] An additional 2,300 individuals are under investigation for misconduct related to Paycheck Protection Program fraud.[11]

Given the enormous scope and dollars involved in the pandemic relief effort it is not surprising that it has been the subject of a significant amount of fraud, and investigations in this area will no doubt continue for years to come. In addition to ripping off monies intended to provide economic relief from the pandemic, fraudsters have peddled phony vaccination cards, used COVID-19 claims to submit claims for unnecessary testing, and stolen identifying information from Medicare beneficiaries seeking COVID related treatment to submit fraudulent claims to government programs. An estimate from recent cases of COVID-19 related false billings to federal programs is $149 million.[12]

Providers should be especially vigilant of any testing/services bundled together with testing/treatment for COVID-19 which is an area subject to federal scrutiny. Vaccine cards should be treated as valuable documents, especially blank ones, held in a secure area and accessible only by those with a legitimate reason to do so.

Antitrust Enforcement in the Healthcare Space

Nowhere has the shift in policy related to healthcare enforcement from the Trump to Biden Administrations been more profound than in the antitrust area. As the saying goes, "there's a new sheriff in town," and President Biden's new Federal Trade Commission ("FTC") Chair, Lina Khan, has made her presence felt in dramatic ways.

Ms. Khan has an expansive view of the FTC's role in the economy, particularly in the healthcare sector. The agency has taken an activist role when it comes to market concentration and competition in healthcare. Mergers of hospital systems and other providers in the past were routinely approved with

minimal FTC scrutiny. That this is no longer the case is best reflected in the aborted merger of RWJBarnabas Health ("RWJBH") and Saint Peter's Healthcare System ("Saint Peters").

The merger of RWJBH had been approved by the New Jersey Attorney General's Office and had the support of unions, managed care organizations and others. Nevertheless, the FTC sued to block the merger, alleging that it would result in competition and higher prices.[13] Days later, rather than fight the FTC, the parties walked away from the proposed merger.[14]

The lesson for providers here is that any business combination must be subject to a rigorous internal antitrust review as routine government approvals can no longer be expected. This is especially true for providers in close proximity to one another and/or who serve similar patient populations.

Conclusion

COVID-19's effects continue to be felt in government fraud and abuse investigations, at times in counter-intuitive ways. Moreover, the change in Presidential administrations has also significantly altered the enforcement landscape. Providers must be flexible to adjust their compliance programs and activities to respond to these shifting priorities and demands. Indeed, if the political winds shift in coming months and control of Congress shifts, we can expect yet more shifts in fraud and abuse investigations.

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[6]CMS March 3, 2022, letter to State Health Officials at 3.

[7]*See, e.g.,* Wall Street Journal, August 15, 2022, lead editorial, *The Government's Stealth Health Takeover* (noting with disapproval the increase in Medicaid rolls by 24 million people due to the CMS's ban on eligibility redeterminations).

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Rethink Revenue Management: Keeping Your Revenue On Course For Financial Success

by Jonathan G. Wiik, MHA MBA CHFP

Jonathan G. Wiik

Hospital revenue management has always been challenging and COVID certainly did not help things. A provider's revenue stream has become extremely volatile, with unpredictable shifts in volumes and consumer behaviors. All while operations, supply and labor costs continue to climb. The current state of healthcare operations is now in full recovery mode and there is a major focus on expense management. The path to financial recovery is front and center at every level of the strategic planning process for providers.

Specifically, major drivers of healthcare disruption have caused strategic focus in six key areas:

- **Workforce**. The Bureau of Labor Statistics reported more than two million job openings in healthcare. Most hospitals are running at 75 to 85 percent capacity in staffing.
- **Automation.** Half of providers are expected to invest in artificial intelligence by 2023, according to a Gartner report. Automation is designed to offset labor and workforce issues.
- **Profitability.** The American Hospital Association noted that uncompensated care increased by $1.1 billion from $41.6B in 2019 to $42.7 billion in 2020. Hospitals have also had six negative months of margin, according to Kaufman Hall's margin index in 2022.
- **Payer mix.** 52 percent of the payer mix on average nationally is going to be funded by government and private insurance or employer-sponsored insurance is going to shrink from about 33 percent to 22 percent. This dilution is going to exacerbate failing revenue projections at most organizations.
- **Health equity.** The pandemic revealed disparities in health equity that must be addressed. Leveraging third-party data sets for social determinants of health to identify socioeconomic insecurities are critical to ensure care and financial outcomes are achievable.
- **Frictionless.** 93 percent of patients indicate that a poor billing experience would prevent them from returning to a provider. An elegant, accurate, and integrated virtual intake management program, along with seamless and flexible payment options, are key elements of a frictionless patient experience.

To address these strategic priorities, many health systems have turned to bolt-on revenue cycle management (RCM) solutions – often from multiple vendors. Unfortunately, these decisions can often make matters worse, accelerating a health system's financial challenges by contributing to recurring denials, underpayments, and high vendor management costs.

To put it simply, RCM vendor performance has been difficult to measure, expensive to maintain and duplicative in its offerings. The result: many healthcare organizations now have an average of 25-40 technology providers dedicated solely to various parts of the revenue cycle. This isn't just complex and siloed, it's detrimental to the business. Sixty-nine percent of hospitals are using multiple vendors, which only results in more shortfalls – namely recurring denials and short pays. In addition, there is universal agreement that collecting data across disparate sources is challenging.

This potpourri of tools also puts a significant burden on information technology (IT), which is already struggling with digital transformation across its infrastructure. Integrations are limited and inconsistent. Functionality is duplicative, as each solution expands beyond its core capability to add additional features that overlap with other vendors' offerings. Maintenance and implementation costs are also climbing, and those dozens of agreements get expensive (and unreasonable) quickly. Every tool claims to solve more problems, better, but instead adds another silo to an expensive, fragmented stack.

The situation is untenable. COVID shook the industry to its core – a race to quick financial recovery, to "recreate the RCM we were before," is a short-sided strategy. We call it the revenue "cy-

cle" because money flows through a set of processes over and over. But this cycle, like a carousel with 50 horses, only goes in circles and isn't effective. There is a better way. Effective healthcare revenue management doesn't need to recreate the cycle. To truly empower healthcare and help it realize its potential, we must break the cycle of inefficiency and rethink revenue management.

Financial leaders must shift their thinking to a new paradigm. A serious, thoughtful, and strategic rethink must occur. Collaboration between patient, provider and payer is needed to advance in this new healthcare economy. Health systems must implement strategies to consolidate vendors and focus on measurable improvements to compete in today's rapidly changing healthcare market. Organizations should look to automate key processes and be as efficient wherever possible. A revolutionary, key performance indicator-based approach fuels holistic revenue improvement**.**

Rethinking revenue management involves a fundamental shift from the traditional cycle of inefficiencies in RCM. For example, health systems that use robotic process automation bots should be able to link that investment to saving the work of several people. It needs to be measurable – let's work smarter, not harder, and automate wherever you can. Intelligent automation is part of the revenue management solution of the future. According to FinThrive research, healthcare finance leaders flagged deep integrations with EHR, other RCM products, and the patient portal as "must haves," along with pre-built analytics and the ability to create custom dashboards and reports. Any tool that can't meet these "must have" requirements should be carefully evaluated in your revenue management platform.

Hospitals are closely evaluating their vendors and are looking to consolidate or eliminate some of partnerships. FinThrive research has also uncovered that almost two-thirds of healthcare finance leaders will invest in a single-vendor RCM platform within the next 12 to 24 months. The shift away from fragmented bolt-on solutions to end-to-end RCM platforms has begun.

The prioritization process should enable revenue management teams to reduce their RCM toolset to five or ten vendors – or even, in an ideal world, just one. This dramatic simplification isn't as far-fetched as it sounds. Healthcare organizations know the current model is broken, and technology providers are racing to fix it.

Centralizing revenue management offers many benefits. Instead of having to pull dozens of different levers across multiple systems, teams can "set it and forget it" and visualize yield and performance in one place. It's less distracting, more efficient, and allows for far fewer opportunities for human and technology error. Not to mention, it's simpler on IT, finance, patient access, procurement, and users alike.

A core revenue management platform consolidates all data in one place for exponentially stronger analyses. A longitudinal data set – that cross-checks discrete RCM pieces – opens the door to a better understanding of what's happening, where, how, and most importantly, what can be done to improve.

A dedicated end-to-end revenue management platform also improves the patient experience. Today's patients expect a cohesive digital experience. For instance, 79% of patients want estimates of their healthcare costs and 56% demand modern digital payment options. By unifying the front, middle, and back-end processes, patients enjoy a much more holistic experience that drives satisfaction and loyalty.

The patient is the new payer. The time is now for our industry to finally address issues of transparency and consumerism together. We have a choice – we can do it, or the government will do it for us. We are already seeing numerous landmark rules and regulations getting passed on transparency, surprise billing and others as our industry has been stuck in neutral. As patients have more choices on where to go, they are going to go where the care is good and accessible but is also somewhat affordable and easy to pay. Frictionless access and payment are critical in the patient as payer paradigm. Patients are consumers who have not gotten ill yet – and they want to shop healthcare like they shop any other good.

Healthcare organizations can't afford to continue riding the carousel of revenue cycle management. Instead, it's time to rethink revenue management with a cohesive platform that empowers organizations to move the needle on profitability. When healthcare organizations no longer juggle a slew of disparate tools, they can focus on what matters: patient care. A unified revenue management platform not only improves the financial health of an organization, but the health of its community.

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Jonathan Wiik has over 25 years of healthcare experience in acute care, health IT and insurance settings. He started his career as a hospital transporter and served in clinical operations, patient access, billing, case management and many other roles at a large not-for-profit acute care hospital and prominent commercial payer before serving as Chief Revenue Officer.

In his current role as Vice President of Health Insights at FinThrive, he is responsible for support and consultation on business development opportunities. Wiik works closely with the market and hospitals on industry best practices for revenue cycle management. He is considered an expert in the industry for healthcare finance, legislation, revenue cycle management and strategic transformation.

Wiik is an active advocate of legislative changes that evolve the healthcare industry. He's the author of Healthcare Revolution: The Patient Is the New Payer, and Revenue Evolution: Helping Providers Get Paid in An Era of Uncertainty, which was released in early 2020. He frequently speaks as a thought leader at state and national events.

Wiik is the President of Colorado HFMA, and previously served as a board member for the American College of Healthcare Executives (ACHE) and Colorado Association of Healthcare Ex-

continued on page 42

Harnessing the Power of Data to Effectively Support and Direct a Pandemic Response

Sean Hopkins

by Sean Hopkins & Amina Razanica

Amina Razanica

Under normal circumstances healthcare and policy leaders are focused on innovative pathways to improving health equity and reducing health vulnerability by mining data to glean insight into where strategic investments can bend the cost curve and improve population health. Patient claims and hospital data alone cannot create a comprehensive picture of community health status. Social determinants data that sheds light on education, employment, income, food and transportation access, and housing, can help paint a community profile that can be utilized to improve health status. Merging clinical and social determinants data creates an insightful tool that providers can use to identify hot spots and target their outreach efforts to create healthier communities.

The power of data to direct and drive healthcare decisions was never more evident than during the onset of the COVID-19 pandemic. The New Jersey Hospital Association's research hub, the Center for Health Analytics, Research and Transformation (CHART) was established with the goal of improving the health of the people of New Jersey. CHART was designed to conduct data analytics, perform predictive modeling, and issue reports, that would have the impact of raising awareness and fostering collaboration and discussion around emerging healthcare issues. Data is seen and read by different people differently, so attention is given to visual representation of data to make it easier to digest by everyone.

During the COVID pandemic CHART's work became a critical component of the pandemic response, informing providers, state health agencies, the Governor, and the public. CHART undertook and created a massive data collection campaign. This data, supplied daily by providers, became the central driver for COVID response analytics. Daily dashboards, identifying hotspots, coordinating PPE allocation, determining visitation protocols, assisting in resource sharing among providers and producing informative bulletins to educate decision makers and the public about the virus, its spread, and mitigation efforts was the end result.

The need and power of data was never more evident than in the beginning of the pandemic. The CHART team's focus was to raise awareness and inform decision makers and providers about changes and nuances in the way the virus was spreading, peaking, subsiding and peaking again. All with the goal of mitigating the spread. These efforts ranged from

- Creating a daily CEO dashboard – broken out by region (North, Central, South) as well as by hospital – that showed
  - the daily number of hospitalized COVID patients
    - number and percent of patients on vents
    - number and percent of patients in an ICU bed
    - ICU capacity
- Creating a data driven, formulaic approach to allocating scarce personal protective equipment drawn from the strategic national stockpile
- Establishing a color-coded visitation policy for hospitals to follow
- Issuing monthly bulletins that were distributed to providers, elected officials, the Administration and the media focused on COVID's impact and interaction with
  - Patients with chronic conditions
  - Vulnerable populations
  - Elderly, nursing home patients
  - Front line hospital staff

Driving change and inspiring action through purposeful use of data analytics to raise awareness, inform critical decisions and to improve the health of populations is a powerful step. Lessons learned in constructing that foundation were invaluable in providing for an ease of transition as the emergency response was crafted on the fly. The lessons learned from the pandemic response will fortify CHART's mission to improve population health, and serve as a roadmap for providers as the COVID pandemic shifts to endemic status, as well as for future pandemics or natural disasters.

Health status varies from community to community. In many instances, a person's zip code is more important than their genetic code when it comes to health status. Social determinant data is the foundation for determining which communities are at the greatest health risk. Many of these communities are low income, with a high percentage of uninsured residents, where the prevalence of chronic conditions, mental health issues and substance misuse are embedded. These communities were also more prone to COVID due to a variety of factors.

Identifying these barriers and breaking them down with data analytics will allow for targeted investments and a healthier society. It will also assist in identifying hot spots or New Jersey's most vulnerable communities (who had the highest virus contraction rate across the state).

Recognizing the power of data is a central component of an emergency response and how when combined with social determinant data, policy makers can use this data in population health management, is an important achievement but more work needs to be done in the area of timely data reporting. Doing so will help save lives in the future.

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Sean J. Hopkins is the Senior Vice President of the Center for Health Analytics, Research & Transformation (CHART) at the New Jersey Hospital Association. He is responsible for overseeing all analytical modeling on behalf of the Association and its members and leads the Association's CHART team in its pursuit of facilitating the Associations mission "to improve the health of the people of New Jersey".

Mr. Hopkins has almost 40 years of experience in the healthcare field. Prior to joining the New Jersey Hospital Association Mr. Hopkins spent ten years with KA Consulting, Inc., a healthcare consulting company located in Edison, New Jersey. Mr. Hopkins graduated from St. Joseph's University, Philadelphia, Pa. in 1981 and earned a Bachelor of Science degree in Accounting.

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continued from page 40

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Preparing for the Unthinkable: How Doylestown Hospital Developed a Business Continuity Plan and Tabletop Exercise for an Extended IT Outage

Richard Lang

Jack Hueter

by Richard Lang, Ed.D & Jack Hueter, MBA, CPA

This article summarizes how Doylestown Hospital developed a Business Continuity Plan and an annual tabletop exercise to lower the risk of business interruptions during extended information technology (IT) downtime.

Cyberthreats continue to rise, and the impact on healthcare is critical. Current threats and resulting outages have the potential to long surpass the 2- to 3-day window most healthcare organizations plan for (in terms of a typical outage duration). The Doylestown exercise started with a basic understanding of the trends that are occurring in the marketplace with healthcare systems specifically experiencing significant outages and downtimes. While the emergence of the Electronic Health Record has revolutionized the transition of healthcare from paper to electronic records, it also introduced the dependence of our IT applications in both patient care and patient revenue. Doylestown Hospital recognized that many Business Continuity Plans and their response protocols were geared to a relatively short timeframe. Understanding that natural disasters and modern cyber threats can cause much longer outages, preparing the organization to think beyond a 72-hour outage was becoming critically important.

Doylestown Health provides a network of care, serving patients and families in the northern suburban communities of Philadelphia, including Bucks and Montgomery Counties in Pennsylvania and Hunterdon and Mercer Counties in New Jersey.

With physician experts in over 50 specialties, Doylestown Health offers the latest therapies for common and complex health conditions. Doylestown Health is also proud to provide retirement and long-term living options in Bucks County, PA through the Pine Run Retirement Community.

Doylestown Hospital, the flagship of Doylestown Health, is part of a clinically integrated system of inpatient and outpatient healthcare services. Additionally, Doylestown Health encompasses:

- Doylestown Health Physicians
- Urgent Care
- Physicians' Offices
- Emergency Services
- Health and Wellness Center
- Outpatient Imaging and Testing
- Home Health & Visiting Nurses
- Pine Run Retirement Community

Establishing a goal for the Doylestown Business Continuity Plan revision was the first step of the project. The goal of the Business Continuity Plan is not to prevent the attacks but to document how each department will function as the IT systems continue to be down for over 72 hours.

Doylestown Hospital had already developed an Emergency Management Plan, an Incident Response Plan and a Disaster Recovery Plan (for IT), and a process with policies and procedures to address Cybersecurity. Recent long-term outages at Vermont Health System and Universal Health System demonstrated that both natural and cybersecurity incidents can cause

significant outages that can have a major impact on health systems. Maintaining departmental operations beyond 72 hours was the concern.

Working closely with Risk Management, Rick Lang, the CIO of Doylestown Health, gained support from the senior executive team to develop a Business Continuity Plan. Digital Health Consulting was selected and engaged to work with the Doylestown CIO and his team to develop this plan.

The project was approved to assist in developing the Doylestown Hospital Business Continuity Plan. It was also noted that this plan is not a replacement for the Emergency Management Plan or the Incident Response Plan but is meant to work together with these plans. The Business Continuity Plan focuses on how departments will function without using IT systems for 72 hours and longer. Also included in the project scope was the development of a high-level Business Impact Analysis to demonstrate the financial impact of a long-term outage.

Doylestown Hospital identified eighteen critical departments to interview. The focus of these interviews was to gain an understanding of what processes and procedures these departments had to continue their operations beyond 72 hours of Information Systems applications that were impacted by either natural disaster or cyber incidents. While Doylestown Hospital had documented downtime procedures and good short-term plans in the Emergency Management and Incident Response plans, it was clear that many departments struggled to articulate how they could function with a long-term outage. Many issues were identified including the need for additional staffing and the skillset needed for staffing, funding for additional resources, and the coordination across the departments for integrating the patient care data.

Digital Health Consulting and the Doylestown leadership team then proceeded to develop a documented plan for the overall coordination of a long-term outage and a standard departmental template for each department that would be included in the plan and provide a detailed process for each department. A key member of the Doylestown team was assigned to work closely with Digital Health Consulting and to take ownership of the Business Continuity Plan following the completion of the engagement.

A draft Business Continuity Plan was then developed. Following approval of the draft plan, a tabletop exercise was scheduled with key Doylestown Hospital administrative and departmental staff. Before the tabletop exercise, Digital Health Consulting and the Doylestown Business Continuity team presented the scope of the tabletop exercise along with an outline of the plan and the departmental templates. This was critical to ensure the departments were fully aware of the goals of the tabletop exercise and were prepared to actively participate.

The tabletop exercise was presented via a web-based group session. Approximately 60 Doylestown Hospital staff participated in a ninety-minute tabletop exercise. Scenarios were developed to simulate long-term outages and the administrative and department personnel actively participated. Digital Health Consulting presented and documented the tabletop exercise. Feedback and recommendations from the Doylestown participants were also documented to make sure the Business Continuity Plan addressed their input.

A summary of the follow-up actions at Doylestown resulting from the tabletop exercise recommendations include:

1. Doylestown Hospital continues to work with each department to develop and update procedures and processes beyond 72 hours.

2. Doylestown Hospital began identifying sources for the additional personnel in the event they are needed from a long-term outage.

3. Digital Health Consulting provided the Business Continuity plan template to Doylestown Hospital which included a standard departmental template. Doylestown continues to work with the departments using the templates.

4. Downtime procedures and processes were enhanced to extend beyond 72 hours.

5. The Doylestown Hospital Business Continuity Plan is a living document and will continue to be updated and modified as needed. An annual tabletop exercise is planned.

In summary, Doylestown Hospital set in motion the ability of its key departments to continue with their clinical and business operations beyond 72 hours. The Business Continuity Plan is a living document at Doylestown Hospital and will annually be reviewed and updated. Having the plan, and the associated procedures, in place is an important destination for all healthcare organizations to follow. This Doylestown project provides a best practice roadmap to achieve a Long-Term Business Continuity Plan to reduce current cyber threats to the healthcare industry.

About the authors

Richard Lang, Ed.D is the retired CIO for Doylestown Health with over 40+ years of healthcare IT experience. Currently he is a full time Assistant Teaching Professor for Penn State University's Abington College Information Sciences and Technology Division. He is also an independent consultant for RDL Healthcare IT Consulting.

Jack Hueter, MBA, CPA is the CEO/Owner of Digital Health Consulting, LLC. Jack has been leading Digital Health Consulting and their assistance with digital transformation for clients for over 12 years, Jack has also worked as a health system CIO for over 25 years.

2022 Proposed Changes to the Medicare Cost Report and Instructions

Jonathan Mason

by Jonathan Mason and Jesse Vo

Jesse Vo

On June 22, 2022, The Centers for Medicare & Medicaid Services (CMS) issued a Federal Register notice pertaining to the CMS-2552-10 *Hospital and Health Care Complex Cost Report,* and included proposed changes to Medicare Cost Reporting instructions.

This new notice contains many of the same proposals from 2020 plus revisions to the Exhibit templates and, in some cases, instructions revised from the previous proposal.

Background

CMS previously issued a Federal Register notice on November 10, 2020, related to form CMS-2552-10 with a 60-day public comment period. In a supporting statement to the June 22, 2022, notice CMS said that due to the number of public comments plus some administrative issues, it was unable to process responses, and the form expired. The notice invited comments through July 22, 2022, on CMS's intention to collect information from the public.

Supporting Documents

A downloadable zip file containing the full set of documents associated with the most recent federal register notice is available on the CMS website under the PRA Listing Section.

The files include:

- **CMS-2552-10. Instructions** from Chapter 40 Hospital and Hospital Health Care Complex Cost Report Form CMS-2552-10 in the Medicare Provider Reimbursement Manual (PRM)
- **CMS-2552-10.___Crosswalk** summarizing the changes and information to be collected
- **CMS-2552-10.Cost Report Form_(P240f)** containing a draft of CMS Form 2552-10 which reflects the proposed changes
- **CMS-2552-10.Supporting_Statement_A_(30-day)** detailing CMS reasoning and justification for new information collection
-

There are also select sections of Electronic Code of Federal Regulations (eCFR):

- **eCFR_413.17**
- **eCFR_413.20**
- **eCFR_413.24**

Proposed Medicare Cost Report Changes

The Federal Register notice highlights changes to the PRM cost reporting instructions and changes to the cost reporting form. These changes include updates to current worksheets instructions and new worksheets.

The affected sections of the cost reporting form are summarized below:

- Worksheet S-2, Part I
- Worksheet S-2, Part II
- Worksheet S-3, Part I
- Worksheet S-10
- Worksheets A, B, C, and D
- Worksheet D-1
- Worksheet D-4
- Worksheet D-6
- Worksheet E-3, Part V
- Worksheet E-5
- Worksheet L-1, Part I

Worksheet S-2, Part I

This worksheet features a new Exhibit 3A with a listing of Medicaid eligible days for Medicare Disproportionate Share Hospital (DSH) eligible hospitals.

Effective with cost reporting periods beginning on or after October 1, 2018, hospitals were required to submit a listing supporting Medicare DSH eligible days claimed in the cost

report at the time of submission. 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 will change.

In addition to revisions in reporting Medicare DSH eligible days' data on Worksheet S-2, Part I lines 24 and 25, columns 1-6, CMS now presents a standardized format to submit the patient-level detailed information. This can be found in the new Exhibit 3A and is required for cost reporting periods beginning on or after October 1, 2022.

Patient-level detail is required for each category of days reported on lines 24 and 25, columns 1 through 6.

The new exhibit, which is found on page 56 of the CMS PRM Chapter 40, has 18 columns and includes the following data points:

- Patient Last Name
- Patient First Name
- Date of Service From
- Date of Service To
- Patient Account Number
- Medical Record Number
- Medicaid Number
- State Eligibility Code
- Worksheet S-2 Part I Column
- Medicaid Eligible Days
- Medicaid Eligible Labor and Delivery room days
- Medicaid Eligible Newborn Days
- Primary Insurance/Payer
- Secondary Insurance/Payer
- Medicare A/B Indicator
- Medicare Start Date
- Medicare End Date
- Comments

Worksheet S-2, Part II

For cost reporting periods beginning on or after October 1, 2022, hospitals are now expected to submit Exhibit 2A, a listing of Medicare bad debts. If applicable, a separate Exhibit 2A should be submitted for each provider number in the health care complex and separated by inpatient and outpatient as well. Also, the exhibits should distinguish between dually eligible crossover accounts and non-dually eligible accounts.

The previous requirement was that providers supply a listing (Exhibit 2) of Medicare bad debts for cost reporting periods beginning on or after October 1, 2018. Failure to do so would result in the rejection of the cost report.

The new exhibit, which is found on page 70 of the CMS PRM Chapter 40, has 25 columns and includes the following data points:

- Patient Last Name
- Patient First Name
- Date of Service From
- Date of Service To
- Patient Account Number
- Medicare Beneficiary ID
- Medicaid Number
- Deemed Indigent
- Medicare Remittance Advice Date
- Medicaid Remittance Advice Date
- Secondary Payer Received Date
- Beneficiary Responsibility Amount
- Date First Bill Sent to Beneficiary
- A/R Write-Off Date
- Sent to Collection Agency Y/N
- Return From Collection Agency Date
- Collection Effort Ceased Date
- Medicare Write-Off Date
- Recoveries Only Amount Received
- Recoveries Only Medicare FYE Date
- Medicare Deductible Amount
- Medicare Co-Insurance Amount
- Current Year Payments Received Amount
- Current Year Payment Received Source
- Allowable Bad Debt Amounts
- Comments

Worksheet S-3 Part I

An update adds Line 34 to report temporary expansion COVID-19 Public Health Emergency (PHE) acute care information.

Worksheet S-10: Proposed Instructions

CMS has revised the Worksheet S-10 instructions. The S-10 worksheet will have a Part I and Part II.

Part I will follow the current reporting instructions where the information reported for uncompensated and indigent care pertain to the entire hospital complex.

New Part II

This will report a subset of that information for only inpatient and outpatient services billed under the hospital CCN. This part focuses on data collection for uncompensated care; the instructions direct lines 2–19 shouldn't be completed for the new worksheet.

These revised instructions would go into effect with cost reporting periods beginning on or after October 1, 2022.

Courtesy Discounts

CMS is clarifying the definition of courtesy discounts and what should be excluded from Worksheet S-10. It's also recognizing an inferred contractual relationship between an insurer and a provider when a provider accepts an amount from an insurer as payment or partial payment, on behalf of an insured patient.

This may impact where charity dollars are reported on Worksheet S-10 as uninsured or insured.

Uninsured Provider Relief Fund (PRF) payments

As seen in current S-10 audits, CMS has updated the instructions to state that hospitals that receive HRSA-administered PRF payments for services provided to uninsured COVID-19 patients must not include the patient charges for those services on Worksheet S-10.

Worksheet S-10: Exhibit 3B

This worksheet has a new Exhibit 3B listing for charity care.

For 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.

For cost reporting periods beginning on or after October 1, 2022, Exhibit 3B represents the new standard format for reporting charity care amounts claimed in the cost report. The new exhibit, which is found on page 131 of the CMS PRM Chapter 40, has 21 columns and includes the following data points with revised definitions included in the proposed PRM:

- Patient Last Name
- Patient First Name
- Date of Service From
- Date of Service To
- Patient Account Number
- Insurance Status
- Primary Payor
- Secondary Payor
- Total Charges for Claim
- Physician Professional Charges
- Deductible/Co-Insurance/Copayment
- Total Third-Party Payments
- Insured Contractual Allowance Amount
- Non-Covered Charges
- Total Patient Payments
- Amounts Written Off as Bad Debt
- Uninsured Discount Amounts
- Charity Care Non-Covered Charges
- Other Charity Care Charges
- Amounts Written off to Charity Care and Uninsured Discounts
- Write-Off Date

Worksheet S-10: Exhibit 3C

A total bad debt detail listing will now be required. This new form, Exhibit 3C, will be required for cost reporting periods beginning on or after October 1, 2022.

The new exhibit, which is found on page 135 of the CMS PRM Chapter 40, has 17 columns and include the following data points with definitions included in the proposed PRM:

- Patient Last Name
- Patient First Name
- Date of Service From
- Date of Service To
- Patient Account Number
- Insurance Status
- Primary Payor
- Secondary Payor
- Service Indicator
- Total Charges for Claim
- Physician Professional Charges
- Total Patient Payments
- Total Third-Party Payments
- Patient Charity Care Amount
- Insured Contractual Allowance Amount
- Write-Off Date
- Amounts Written Off as Bad Debt

Worksheets A, B, C, and D

In Worksheet A; Parts I, II, and B-1 of Worksheet B; Parts I and II of Worksheet C; and Parts II, IV and V, D-3, D-5 Part IV of Worksheet D, instructions were updated to clarify reporting for:

- Allogeneic hematopoietic stem cell
- Chimeric antigen receptor T-cell therapy
- Opioid Treatment Program acquisition costs

Worksheet D-1

Changes to the computation of inpatient operating costs include the addition of new lines to reflect temporary and permanent adjustments to TEFRA rates to properly calculate the TEFRA limit for inpatient costs.

Worksheet D-4

Instructions for computation of organ acquisition costs have been revised regarding the counting of organs including total usable organs, Medicare usable organs, organs for Medicare Advantage patients, and organs that have a primary and secondary payer.

Worksheet D-6

Worksheet D-6, *Computation of Acquisition Costs*, and instructions, was added to calculate the inpatient routine, ancillary, and other costs associated with the acquisition of allogeneic HSCT as required under Section 108 of the Further Consolidated Appropriations Act, 2020 (Pub. L. 116-94).

continued on page 49

What Does an Effective Patient Assistance Program Look Like?

Cris Hartigan

by Cris Hartigan

Increasing healthcare and drug prices force many patients to consider forgoing treatment or go into debt. Costs are exponentially worse for patients facing cancer and other complex diseases that require specialty therapies. To relieve this pressure and ensure patients don't have to choose between their health and putting food on the table, many healthcare providers leverage patient assistance programs. While these programs are invaluable, they come with their own complexities, making supporting vulnerable patients a challenge.

Let's explore why hospitals and health systems leverage patient assistance programs, key challenges with execution, and solutions to overcome those obstacles.

Why Hospitals and Health Systems Have Patient Assistance Programs

Patient assistance programs deliver philanthropic medical financial aid by providing copay assistance or free drugs to patients that can't afford treatment or don't qualify for traditional government programs like Medicaid. Through this opportunity, hospitals and health systems help their patients receive the care they need, no matter their financial situation. This support reduces financial distress and improves clinically relevant patient outcomes such as quality of life, medication adherence, symptom management, and survival. Mission-oriented care providers who connect patients with this critical funding are viewed as trusted organizations and sought after. An effective assistance program is a great competitive differentiator. There are financial benefits for healthcare organizations as well, including reduced drug spend, decreased uncompensated care, and faster resolution of open A/R.

The Primary Challenges of Patient Assistance Programs

The landscape of patient assistance programs is complex. Healthcare organizations struggle to gain complete visibility into the plethora of available philanthropic medical financial aid opportunities. Remarkably, there are currently more than 20,000 patient assistance and social support programs offering $30B in aid annually. However, it is hard to discover and access each unique program. The various eligibility rules, enrollment policies, and reimbursement processes add to the challenge. Changes to existing programs and new opportunities necessitate constant monitoring.

Additionally, there are major resource challenges in staffing, data, and workflow to progress from a program match to an award. Identifying eligible patients and enrolling them prior to procedures and prescription fills is a task in itself. There are many forms to complete. Organizing data silos inside and outside hospital and health system electronic health records (EHRs), billing systems, assistance programs, and patients all require effort. Other administrative demands include managing supplied drugs, billing, tracking, and reporting.

Coordination challenges also impact patient assistance program effectiveness. Hospital and health system stakeholders, from revenue cycle to pharmacy and clinical operations teams, must partner and align for success. Efficient operational logistics are a must to ensure a productive and compliant program.

Solving Patient Assistance Program Challenges

Fortunately, powerful platforms are available for providers to advance health equity, reduce bad debt, and increase cash collections through philanthropic aid. When evaluating patient assistance solutions, consider the following five criteria:

1) A Comprehensive Database: Artificial intelligence (AI) can screen patients for opportunities from a comprehensive database of over 20,000 programs. This uncovers diagnosis-based assistance, copay assistance, free drug, and social support programs tailored to each eligible patient's needs.

2) Ease of Integration: Integration with EHR and billing systems ensures every opportunity is explored across any type of medical encounter or specialty prescription. Clearinghouse

integration also enables staff to efficiently submit claims, track status, and log payments from one platform.

3) Enhanced Automation: Automated program forms with EHR data can expedite enrollment and reduce stress for financial navigators, care coordinators, pharmacy technicians, advocates, and patients. Patient information, consent, and required documents collected digitally provide a better patient experience. This also reduces the need to download, print, scan, or fax.

4) Productivity & Compliance: Hospitals and health systems benefit from a single, centralized system to store all internal and external medical financial aid documents in one archive. This improves productivity for users who require similar documents across various programs and mitigates compliance risk.

5) Driving Outcomes: Technology delivers critical reporting and workflow alerts to track staff efficiency, ensure the maximum number of patients are supported, and quantify reimbursement secured. This level of detail is also helpful for Medicare Cost Reports, Community Health Needs Assessment initiatives, and 340B covered entities.

Attend the HFMA NJ and Metro Philadelphia Chapters 46th Annual Institute to Learn More

Want to go deeper on how to optimize your patient assistance program and how HFMA's President and CEO Joseph Fifer's annual themes of CEoH (cost effectiveness of health) and SDoH (social determinants of health) apply? We hope you will attend Atlas Health and Tufts Medicine's educational session, *Patient Assistance & Health Equity: A $30B Revenue Cycle Opportunity*, at the 46th Annual Institute at The Borgata in Atlantic City, NJ. Join us on Thursday, October 27 from 2:05-2:55 PM in Breakout #5 to learn best practices across stakeholders, processes, and technology that will help your hospital or health system achieve the best patient outcomes and financial results.

About the author
SVP Sales, Atlas Health

Cris Hartigan is the Senior Vice President of Sales at Atlas Health. He began his career in retail and manufacturing which set his foundation for the customer experience. For the last 20 years, Cris has served as a healthcare executive at MD-X Solutions, MedAssets, and nThrive, advancing revenue cycle solutions to improve providers' margins and empower them to deliver on their mission. Joining Atlas Health in 2021 provided Cris the opportunity to advance health equity for the most vulnerable populations. However, he remains most proud of his family and their ongoing achievements. Cris can be reached at cris.hartigan@atlas.health.

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continued from page 47

Worksheet E-3, Part V

Line 3.01 and instructions for cellular therapy acquisition cost were added.

Worksheet E-5

This worksheet, *Outlier Reconciliation at Tentative Settlement*, was added, with instructions, for contractor use, to report the outlier reconciliation amount during cost report tentative settlement.

Worksheet L-1, Part I

This worksheet was revised to add line 78 for CAR T-cell immunotherapy costs and to add line 102 for Opioid Treatment Program.

Potential Challenges and Considerations

It's anticipated that CMS will likely release a final notice. Additional reporting requirements could bring up challenges for providers depending on their current cost reporting practices.

Providers that rely on Medicaid payment as documentation for inclusion in the Medicare DSH calculation now face the issue of having to report detailed Medicaid eligibility information on worksheet S-2—including state eligibility codes—in the new exhibit 3A for all patients.

The addition of the required templates for charity and bad debt creates several new challenges and increased effort for the provider on worksheet S-10. Each account on both listings will need to be reconciled to ensure that all the activity from each patient account is recorded in the correct columns.

Please reach out to discuss how these proposed changes will affect your organization and Medicare cost reporting efforts. Additionally, join us October 27, 2022, during the New Jersey and Metro Philadelphia HFMA Annual Institute where we'll be discussing more about this topic and other pressing reimbursement issues.

About the authors

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

Jesse Vo has worked in the health care finance industry since 2011. His primary area of focus is provider reimbursement, in which he assists hospitals and health systems report their Medicare Disproportionate Share Payments (DSH) and uncompensated care reimbursement. Jesse Vo can be reached at jesse.vo@mossadams.com.

Complying with Value-Based Risk as Healthcare Providers Transition from Fee-for-Service

Brian S. Kern

by Brian S. Kern, Esq. & Debbie Nappi, CPA, MST

Debbie Nappi

With the start of every new year, we reflect on the progress we have made in the past and the changes that are needed as we move forward into the future. The same holds true for the future of the healthcare industry as we continue to transition away from fee-for-service models and embrace the value-based payment models that reimburse providers for the clinical management of patients served, rather than the volume of patients that were seen.

The transition from fee-for-service to value-based healthcare reimbursement has prompted provider groups to reconsider their positions on the continuum of care with payors. Most physician practices still under the fee-for-service models are branching out and starting to sign up for value-based arrangements. Many have realized that taking on financial risk, although difficult, is the key to future success and have moved into "at-risk" contracts. In doing so, much consideration is needed, as taking on financial risk can expose other areas of liability, which should be factored in during the due diligence process.

The fee-for-service model has been a profitable and comfortable one for many healthcare providers, and thus there has been hesitancy to move into a shared risk model. Most such models have been limited to "upside risk" – allowing providers to share in savings when delivering care more efficiently. Now providers are expected to share in down-side risk – requiring that providers refund a payor if the actual cost of care exceeds the agreed upon financial benchmarks for care delivery. Though providers must now share in the down-side risk in these models, the financial rewards for providers who excel in these programs are most advantageous.

Value-based models are based on patient care management which rewards efficiency, meeting quality metrics, and achieving favorable patient outcomes. Participants must produce positive clinical results while managing the cost associated with patient care. Tools such as advanced analytics and data procurement are available in the form of dashboards and customized reports, which pave the way to predictive analytics to assist in the modeling of the cost of care for physician practices and healthcare systems.

Types of value-based payment models include:

1. **Shared savings** – an organization is paid based on the traditional fee-for-service model and then an annual accounting is completed to compare total spending to the agreed upon target. If your organization was below the target, a bonus will be issued.
2. **Bundled payments** – a payor bundles costs for a procedure or an episode of care. All providers share the bundled payment.
3. **Shared risk** – in addition to shared savings, a healthcare entity would also share in the additional cost that exceeds the targeted amount.
4. **Global capitation** – the entity receives a per-patient monthly payment for the individual's care.

The value-based models are offered by the following:

Center for Medicare and Medicaid Services (CMS)

CMS has been testing new payment models – with varying levels of risk – for years. Of the models that include downside risk, the government has set up frameworks to ensure groups can absorb losses. Repayment mechanisms include lump sum payments back to CMS and reductions in future remuneration for physician participants. CMS also requires a form of collateral (see below), though the collateral itself rarely covers the risk.

CMS has a goal of having 100% of Medicare providers in meaningful downside risk programs by 2025.

Private/Commercial Payors

Commercial models tend to be watered down versions of government models. Payors often resist meaningful data – sharing and pressuring participants to purchase stop-loss insurance directly from the payors – limiting significant risk taking.

A few collaborative payors have built models that include true data and risk-sharing. While the benchmarks and target prices are negotiated, these programs can have considerable risk. The implications of the risk, and whether to transfer it, depend on individual circumstances.

Employers

Groups that contract directly with self-insured employers might do so with agreed-upon rates. If so, providers essentially guarantee costs. These models reflect what a true competitive market looks like. Unless special interests derail healthcare transparency, they are also what the future of healthcare delivery will look like.

Indeed, healthcare risk would no longer relate to the nuanced and complex rules of the government and commercial payor programs. Rather, the risk would be in failing to deliver care at the cost advertised. Healthcare becomes an open, functioning marketplace.

The Risk

Collateral

Whether dealing with the government, commercial payors, or employers, posting certain forms of collateral may be necessary under value-based models. Collateral may include a letter of credit, an escrow account, or a surety bond. Stop-loss insurance – though not always accepted as collateral – is often used to backstop any risk, limiting overall exposure, stabilizing balance sheets, and placating investors and creditors.

Risk-Bearing Structure

Depending on the structure and sophistication of the participating provider group, it may elect to file to become a risk bearing entity, such as an organized delivery system (ODS). Absent specific regulations, risk-taking entities may maintain their current structures and simply pay losses if/ when they come due. Small companies will generally purchase stop-loss which provides for a reasonable deductible and the liquidity needed upon a loss occurrence.

Larger entities often create captive insurance plans to handle risk. Captives allow companies to self-insure a certain amount of risk and purchase reinsurance above that amount. Managing a captive requires a serious time and capital commitment along with a myriad of reporting requirements.

Captives have also come under scrutiny in recent years for not having adequate risk transfer and thus serving merely as tax shelters. Captive managers and other consultants can assist groups comply with myriad regulations associated with captive insurance products.

Risk taking is propelling many provider groups to the top of the care continuum. Responsible, calculated risk takers will continue to bring them closer to the premium dollar. Those who ignore the compliance side of risk taking do so at their own peril, and the peril of others who are impacted.

Compliance

Guarantors

Investors, and any employees used for purposes of collateral, should be considered in the decision to take on risk. If physician employees end up having their payments reduced due to poor performance under a value-based care program, employers will then bear the burden of the associated liability. Employers can also be liable to investors depending upon the relationship.

Management services organizations (MSOs) attract and often have private equity funding, which expects a healthy return on its investment. MSOs should provide full transparency into the terms of the deals being negotiated on behalf of physicians and investors alike. Details of VBC models can be extremely complicated, particularly when it comes to coding and risk adjustment. Everyone with a material financial stake should be apprised of, and comfortable with, the terms of downside risk deals and their maximum potential losses.

Balance Sheet Reporting

Private equity (PE) infusion is frequently utilized to facilitate acquisitions. When MSOs put PE dollars at risk – without sufficient insurance – it can create balance sheet inequity since the estimated loss, if not secured by insurance, is subject to financial reporting by the healthcare entity and (depending upon the circumstances) must be reflected as a liability or as a footnote to the financial statements to alert the readers of the loss occurrence. The best way to keep capital free is to hedge VBC risk.

Stop-Loss / Reinsurance

Stop-loss insurance is used as a tool to ensure financial stability and meet obligations to creditors and investors.

Given the breadth of liability associated with taking on risk, large payors have learned how to leverage stop-loss insurance. Newer entrants into healthcare risk taking often do not have the same tools or access to reinsurance dollars.

However, the stop-loss market for downside risk in VBC models has been developing new capabilities to support provider groups. Groups should not go at-risk without conducting due diligence on the cost and availability of risk transfer options.

Accounting / Legal / Financing

Contracts should be reviewed to ensure compliance. Review provisions in agreements with lenders, investors, credi-

continued on page 53

Optimizing Your Revenue Integrity Program: Objectives, Strategies, Staffing and Performance

Caroline Znaniec

by Caroline Znaniec, MBA, MS-HCA

Changes in the healthcare industry due to greater constraints on budget, lack of available skill sets, reactive cultures, and the inability to measure performance or defining what to measure has shone more light on the need for a formally structured revenue integrity program. While the need is identified, many organizations question ***How do I do more with less and do so effectively?*** Organizations should focus on four main items: objectives, strategies, staffing, and performance.

Objectives:

Better performing revenue integrity programs have clear objectives with defined roles and expectations. This prevents overlap between functions, including those of the billing office, compliance, internal audit, and clinical operations. Providing a clear objective through a revenue integrity program charter is a great place to start.

Strategies

In addition to stating the objectives of the revenue integrity program, there are key strategies that help to maintain focus to meet objectives. Better performing organizations employ the specific strategies in the creation, implementation, and sustainment of their revenue integrity programs. All the strategies provided, when combined, create a culture of revenue integrity within a provider organization which is most important to sustaining the program and its efforts. These strategies include the following:

Create staff awareness at all levels on the individual and provider organization's responsibilities through inclusion of responsibilities in job descriptions, on-boarding activities and annual education.

- Provide periodic reviews across the organization in a well-defined, documented, and thorough manner through the creation and implementation of an annual work plan
- Design and implement a monitoring program for high-risk areas identified to include the development of review tools, analysis of results to identify root causes and develop corrective action plans, track corrective action plan implementation, and verify improvement
- Create and maintain a revenue integrity committee (or similar initiative) to ensure the program is meeting its primary objectives
- Communicate findings of the revenue integrity monitoring activities to executive management

Staffing

As staffing shortages persist, provider organizations are looking at different ways to continue to support sound revenue cycle functions. For many organizations, the staffing shortages have provided an opportunity to revisit their objectives and strategies for success. One important aspect of that is right-sizing the staff to match.

Underperforming Metric (example)	How Other Metrics May Appear/Respond
Clean claim rate	• Decreased medical necessity check rate • Decreased insurance verification rate • Increased registration error rate • Increased late charges • Decreased coder productivity and quality • Increased claim editing volume • Decreased biller productivity and quality • Increased cost to collect

Additional strategies include upskilling and re-skilling existing resources, leveraging automation to improve efficiencies, optimizing the use of technology to identify areas of priority, looking to business partners for short-term project needs, or complete outsourcing. With the strategies provided, organiza-

tions can regain their momentum to improve revenue integrity as we continue through 2022 and beyond.

Performance

Measuring the performance of the revenue cycle overall can aid in gauging not only where you are, but where you have been and set the pace for where the organization wants to be. For many organizations, metrics are available as well as tools to visualize performance. Where revenue integrity can make the larger impact is telling the story around the metrics, how they are trending and why. It's important to not focus on a single metric as many are related and interdependent. Understanding the relationship between metrics can better identify where resources should focus to correct the root cause issue hindering better performance. For an example of how one underperforming metric may affect others.

In relaying performance and improvement activities, revenue integrity should not rely solely on dashboards and other reports. A narrative summary to executive management, along with visuals, can further create the buy-in that is important to maintaining momentum and support for the program overall.

Learn more about how to optimize your revenue integrity program at the NJ/Metro PA Annual Institute.

Opinions expressed are the author's and do not represent those of HFMA, AHIA, NAHRI, AAHAM, or any of its subsidiaries, or Protiviti.

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continued from page 51

tors, or vendors to determine if any require prior notice before entering into new risk sharing programs.

When taking on risk with multiple parties, be sure that the same collateral is not utilized more than once. On annual financial statements, liabilities should be properly addressed and classified. They should also be "valued" appropriately to avoid additional risk.

Conclusion

Value-based healthcare will continue to be the future of healthcare. To gain control within the new value-based healthcare delivery system, healthcare organizations need to manage clinical data and the down-side risk inherent in value-based models. Understanding how to use risk transfer mechanisms effectively can not only reduce liability under the value-based models themselves, but liability from countless other areas, and result in greater financial rewards for your healthcare organization. Please consult with your team of professionals to assist you in the process of migrating forward in value-based healthcare.

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Forging a Path to Financial Sustainability For Hospitals and Health Systems

David Gregory

Mary Ellen Kasey

Bret Ammons

by David Gregory, Mary Ellen Kasey and Bret Ammons

Healthcare executives have a long list of concerns in today's challenging environment, and improving financial performance and operating margins is at the top – or near the top – of the list. Given the financial fallout from the COVID-19 pandemic, a consistent and systematic approach to managing clinical and financial performance will be required in order for healthcare provider organizations to rebound. There are a number of other key priority areas that need to be a focus in order to achieve financial sustainability, including:

— Reassessing **service line financial performance** through new revenue streams and cost containment initiatives

— Deploying **innovative technology** to streamline workflows and more effectively manage the business

— Analyze and optimize managed care contracts to maximize revenue and engage in **value-based care (VBC) negotiations** that can new and steady revenue streams

— Growth through mergers and acquisitions to enhance physician networks, expand geographic reach, **diversify service offerings** and provide scale that may be necessary to reduce overall system costs

— For multi-hospital systems, evaluating efficiencies and synergies of operating as a **integrated delivery network**

- Expand your health system's ability to meet local social needs like affordable housing, food insecurity and other important social determinants of health (**SDoH)**
- Leverage your EMR system to its maximum potential in managing your business as well as generating Real-World Evidence (RWE)
- Embrace ways to manage labor challenges through innovative programs like Hospital-at-Home (H@H)

The words "financial sustainability" have increasingly become two of the most widely used words in the healthcare industry, due in part to the COVID-19 pandemic and its impact on operating margins. Even with the significant government funding that has been used to offset the negative financial impacts of the pandemic, COVID-19 continues to have a tremendous financial impact on the industry and may be considered the most significant disruption in operations that any hospital or health system has ever experienced. This disruption is expected to result in long-term economic pressures that will impact healthcare providers for years to come – and the rating agencies have taken notice. For example:

— Moody's Investors Service shifted its outlook for U.S. not-for-profit and for-profit hospitals from stable to negative.

— Fitch Ratings reported a negative outlook for not-for-profit hospitals and healthcare systems.

— Standard & Poor's revised its outlook for the not-for-profit acute care sector from stable to negative.

More recently, in the July 2022, Kaufman Hall *National Hospital Flash Report* it was reported that U.S. hospital and health systems are now halfway through the current extremely challenging year. While margins were up in June compared to May 2022, expenses remain at historic highs, leaving hospitals with cumulatively negative margins.

Hospitals continue to face difficult and operational challenges. This current report indicates that although margins are rising, decreases in acuity, escalations in outpatient volume

and easing costs in June show that hospitals are faring better month-over-month, but are nowhere near pre-pandemic levels. Margins are still in the red and will likely remain historically low for the remainder of 2022. While labor efficiency is improving, rising employee pay and additional labor pressures along with inflation are keeping overall expenses high.

No Margin, No Mission

Maintaining a positive operating margin is essential for the long-term survival of any organization, regardless of the industry in which it operates. In the healthcare provider environment, positive operating margins allow for investments in new facilities, treatments and technologies, all of which facilitate high-quality care for patients. A positive operating margin also helps ensure the ability to attract and retain frontline caregivers and other critical staff and to purchase necessary medical supplies and equipment.

In addition to providing best-in-class daily care for patients, focusing on financial sustainability will allow the healthcare industry to:

Invest strategically to maintain market relevance

Baker Tilly believes population health management is integral to planning for and maintaining financial sustainability. As such, hospitals and health systems will need to invest in new priorities, including healthcare IT and analytics platforms for preventive health measures, patient programming/patient engagement and physician engagement. In summary, it is all about ensuring healthcare providers are driving value by remaining relevant in the communities they serve.

However, it is also important to note that some health systems who led the way in population health and VBC are rethinking the long-term value of the strategy and are looking to states like Maryland with their global budget approach as a way to advance in a financially sustainable way.

Evaluate overall business on an ongoing basis, including revenue generation and growth, cost accounting and cost management

Hospitals and health systems are generally expected to tolerate a higher level of financial risk than they have been comfortable with in the past. Moving into areas beyond acute care delivery, entering new partnerships and expanding population health offerings are examples of initiatives that typically come with an elevated level of concern. To mitigate financial risk, it is important for hospital leaders to understand the direct and indirect costs of running their organization in the short-term, and how these costs intersect with long-term business strategy.

A detailed understanding of direct cost drivers will facilitate more comprehensive service line improvements that improve the overall financial health of the organization. For many healthcare providers, assessing the total costs – direct and indirect – of specific clinical activities is still relatively cumbersome. Healthcare cost accounting is immature compared to other industries such as retail or manufacturing, and typically incorporates a large degree of manual allocation of costs. For any business to be sustainable, leaders must know the cost to produce and deliver products and services so the business can generate sufficient revenue to cover operating expenses. Without accurate costing data, it is very difficult for organizations to make informed operational decisions.

Furthermore, unlike most other industries, revenue leakage at a service line level must be factored in if an appropriate model of performance is to be used to generate improvements. Our research indicates that payer denials and unfavorable variations between actual and expected reimbursement are not analyzed at the service line level, but instead managed at a system-wide level, which leads to enterprise improvement initiatives that fail to make a material impact at the service line level. In summary, it's time to peel the onion and get into the details to effect change within the organization. Clinical and financial integration is also critical here, as this enables more recognition and avoidance of volume leakage and increases market leverage for important contracts and partnerships.

In addition to securing a more granular understanding of operating performance within the organization, physician practice management is an example of one area within a healthcare system that is under increased levels of scrutiny. The level of importance regarding a comprehensive understanding of the revenues generated and expenses incurred by the physician practice component of a typical healthcare system has been elevated and, for most providers, rightfully so.

Financial sustainability and improvement strategies

Healthcare provider organizations are constantly striving against slipping financial performance measures. Most organizations rely heavily on Medicare and Medicaid as major contributors to business volume, yet those two payers generally reimburse significantly less per episode than commercial plans and even one's cost of care.

Based on the most recent pre-pandemic data from the Center for Medicare and Medicaid Services (CMS), on average, short-term acute care hospitals were incurring losses on Medicare admissions; in 2017, the average loss approximated 10% of the average payment. Further, according to data from Medicare Provider Analysis and Review (MEDPAR), short-term acute care hospitals have experienced higher average losses per admission each year from 2017 to 2019.

There are many contributing factors to the average losses per admission, including less than adequate reimbursement levels from Medicare and a variety of other operational factors. In addition, 67% of medical practices reported that 2019 Medicare payments did not cover the cost of delivering care to beneficiaries. These trends continue even as providers are focusing on recovery from their pandemic losses.

It should also be noted that, with the continued consolidation

between hospitals and health systems, group practices and sole practitioners, commercial reimbursement rates are rising due to the additional leverage a larger provider organization may have with insurers. However, commercial contract negotiations are becoming increasingly difficult, as commercial payers are also trying to manage their costs.

Provider organizations should engage in competitive benchmarking of their managed care contracts to ensure that they are receiving fair market rates for their services from their major payer contracts. As part of these reviews, analyzing the potential positive revenue impact of value-based care programs is key – many contracts contain these provisions and providers frequently underperform in this area which can often be easily corrected with a focus on quality in documentation. In addition, Medicare and commercial MA contracts are prime areas to leverage larger revenue share through fine-tuning of your value-based workflows and processes. Provider organizations leave millions of dollars from Medicare on the table each year because they can't capture quality measurements in their data.

Furthermore, organizations that care for higher concentrations of seniors, and perform a lower volume of elective surgeries, are more vulnerable in uncertain times (e.g., during the COVID-19 pandemic). These circumstances require provider organizations to focus on denials more intently, cost containment and reduction of reimbursement leakage in order to remain financially sustainable. Other performance improvement strategies may include the implementation of innovative staffing models, more effective supply chain management, reducing administrative costs and renegotiation of managed care contracts with a focus on maximizing the steady revenue streams of value-based care programs.

However, there are four (4) critical but challenging success factors when implementing strategies for financial sustainability programs:

1. How to identify performance improvement opportunities that will have the most significant impact on an organization's financial health (i.e., how to prioritize the opportunities)
2. How to evaluate operations from a cost AND reimbursement perspective in order to pull both levers that drive financial performance.
3. How to invest in social infrastructure/programs that will generate a meaningful ROI for the health system
4. How to collect and utilize the health system's own RWE to positively influence care pathways and VBC relationships.

Operating margin pressure is generally being caused by some form of reimbursement pressure (e.g., governmental reimbursement rates not sufficient to cover the cost of care, elevated level of intensity relative to renegotiating contracts with commercial payers, etc.), as well as increasing operating costs. Further financial challenges posed by COVID-19, including the suspension of elective procedures and increased ongoing operational costs (e.g., personal protective equipment) are putting further pressure on already tight margins. In trying to navigate the "new normal" in a healthcare setting, having an understanding of the operational levers that can be pulled to make improvements to financial performance will be crucial.

In summary, we believe that the primary keys to improving financial performance and achieving financial sustainability start with understanding and improving service line profitability and improving revenue cycle performance.

Leveraging analytics to improve service line profitability

Gartner defines "augmented analytics" as the following:

"Augmented analytics is the use of enabling technologies such as machine learning and AI to assist with data preparation, insight generation and insight explanation to augment how people explore and analyze data in analytics and BI platforms. It also augments the expert and citizen data scientists by automating many aspects of data science, machine learning, and AI model development, management and deployment."

The ability to aggregate data on a granular level and utilize it in a meaningful way is paramount at all levels and functions within an organization. From making strategic decisions at the executive level to creating operational efficiencies and measuring operational performance, investing resources, time and energy in advanced data analytics solutions is key to achieving financial success.

There are two key characteristics that should be built into the analytic solution set for optimal and sophisticated service line financial performance analysis:

1. Granular encounter/claims data should be the core dataset.
2. Both cost and reimbursement data should be incorporated at a detailed claim level and then aggregated to determine anomalies and poor performance.

Effectively incorporating a claim-level analytics strategy into financial sustainability initiatives is critical in today's ever-changing environment. Healthcare provider organizations also need this level of detailed analytics to effectively stratify patient populations. This allows those organizations to develop care coordination strategies across the care continuum that are targeted to proactively treat specific populations, reduce the cost of care, improve outcomes and increase performance metrics. Being able to analyze top diagnosis-related groups (DRGs) and outpatient procedures along with high-cost physicians, members, conditions, devices and drugs will enable systems to affect performance metrics and manage risk more proactively. In addition to analyzing DRGs, CPTs and HCPCs at the service line level, the Baker Tilly Financial Performance Institute recommends examining referral and contracting patterns to better understand if reimbursement is being reduced for items such as transfer DRGs and DRG/procedure downgrades.

A successful analytics program relies on accurate data from multiple sources. For providers without insurance arms, leveraging and consolidating payer data is critical to analytic success; payers can deliver information across all types and settings of care, whether in-network or out-of-network. Therefore, detailed reimbursement data should also be incorporated into the analytic process in order to track specific reimbursement levels for each procedure or service line at the payer and plan level of granularity.

Being able to understand comparative performance is another key factor for success. Having an effective category comparison approach provides a calibrated view of trends that allows healthcare organizations to respond with targeted interventions. For example, relative physician performance, adjusted for volume and severity, shows which physicians are performing below metric thresholds and can be used to drive an effective engagement strategy to help those physicians improve outcomes. Healthcare provider organizations should consider the following types of comparison analysis:

- Payer-to-payer, specifically at the procedure level
- Provider-to-provider
- Performance metrics to local and regional averages
- Service line costs and reimbursement
- Year over year performance at the business unit level

Obviously, physician engagement in a patient's care is critical to ensure hospitals and health systems are optimizing reimbursement for services rendered. This requires those organizations to involve physician leadership from the beginning of the improvement initiative in designing an effective program that looks at all facets of the physician relationship, from compensation strategies to care delivery models and performance management via a consensus-driven analytics platform. Engaged physicians are far more likely to involve their patients in managing their own outcomes – which brings us to the key element of the equation: patient engagement is as critical as physician engagement and requires the right balance of frequency, content, tone and follow-up, all backed up by credible data.

Improving revenue cycle performance

Further compounding the challenges of analyzing financial sustainability is the difficulty of forecasting operational outcomes, due in part to the highly unpredictable operating environment for healthcare providers. In order to mitigate the unknown, our research indicates that in addition to cost management, a renewed focus on efficient and effective revenue cycle management is paramount to improving service line profitability and is critical for hospitals and health systems to remain financially sustainable.

Managing denials

One method provider organizations should to consider as a way to mitigate future denial occurrences and to operationally understand corrective action for resubmitting rejected reimbursements is to utilize the aforementioned augmented data analytics and leverage the capability to analyze payer 835 remittance data at a detailed level. This will help provider organization to better understand not only why denials occur (e.g., lack of authorization), but also by what payers and for which specific services (i.e., both inpatient DRGs and outpatient procedures).

Enhancing overall AR analysis through utilization of technology

In addition to revenue leakage, the timely billing and collection for services rendered is critical to all service line performance measurements. By shrinking the time required to obtain reimbursement, organizations can evaluate financial performance much sooner in the cycle and make improvement decisions quicker in order to maximize annual performance. Utilizing technology to more effectively summarize the condition of a provider's accounts receivable (AR) via dashboard type reports is one way of enhancing the billing and collection cycle.

Conclusion

Forecasting the results of future operations is extremely difficult, due in part to the ever-changing operating environment for healthcare providers. With the use of advanced data analytics solutions, hospitals and health systems are able to utilize granular levels of data to help make more informed decisions at all levels within their organization. By having this renewed focus on efficient and effective revenue cycle management, cost management and service line profitability, healthcare providers are able to begin, or continue, their journey on a path to a more sustainable financial future.

In summary, the current environment demands a blend of innovation and diligence to achieve and then maintain financial sustainability. This Baker Tilly insights report on the power of precision analytics is just one aspect of a comprehensive approach to sustainability.

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Care Management's Role in Aligning Clinical Revenue

Valorie Clouse

by Valorie Clouse RN, AGNP, FNP, CCM

Prior to the pandemic, many utilization review (UR) staff were working remotely—but now that remote work is even more common, your organization may face additional costs as a result of foregoing the concurrent review process in favor of the retrospective review process. The concurrent process can be time-consuming, but in reality, it can be cost-beneficial when factoring in avoided denials and level of care downgrades. Reaching an attending physician prior to discharge can be much easier than reaching them after a patient has been discharged.

The financial difference of a concurrent process versus a retrospective process can be consequential. For example, with a concurrent Condition Code 44 process, a single outpatient Part B claim is submitted upon discharge. If completed early in the inpatient stay, a new order for outpatient with observation services may be written, allowing for an APC payment including observation time. With the retrospective self-denial/rebill process, there would be no observation, room and board, or nursing care charges to bill for, resulting in a significant reduction in reimbursement through the rebilling process. Thus, the retrospective process could result in a significant revenue loss for hospitals—based on some estimates of more than $1,300 per claim—as well as a delay in payment due to the layered claim processing requirements. For the self-denial/rebill process, a hospital stay must first be billed as a self-denied claim, which is processed by the Medicare Administrative Contractor. Then hospital coders and billers must prepare two rebilled claims resulting in hospital stays being coded and submitted a total of three times, which can significantly increase staff workload and reduce efficiency.

It's crucial that UR staff and hospital leadership understand the implications of concurrent versus retrospective review prior to choosing one. Consistently utilizing a selected process can help patients receive the correct level of care at the correct time and help hospitals deliver appropriate and cost-effective care while reducing claim denials for improper billing or inappropriate services. Detailed policies, procedures, and staff job descriptions are necessary for developing and implementing an effective utilization review process.

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Health Care Staffing Strategies Now, Next And Beyond

Roselyn Feinsod

by Roselyn Feinsod

As we've been discussing since the pandemic began, the health care staffing crisis is surging across the country, with many hospitals and health systems continuing to experience significant challenges in filling vital clinical roles. According to the EY 2022 Work Reimagined Survey,[1] 37% of health care employees say they are likely to leave their employer in the next 12 months. Another survey found that two-thirds of nurses are seeking to exit health care completely — up nearly 40% from the same time in 2021.[2] What's more, 1 million nurses are expected to retire in the next 10 to 15 years,[3] and this looming nursing shortage is exacerbated by deficits in available nursing instructors across the country.[4] For health organizations, transformation across operations, technology, care setting and delivery, and more will be essential to stem attrition. Below are several talent-related changes that health care leaders should consider implementing as they navigate these headwinds.

What we know about health care worker pain points

While burnout concerns continue to have a significant impact on quit rates among health care staff, important issues around total rewards, workforce planning and culture are driving the current state. Our research and analysis — including the EY 2022 Work Reimagined Survey of almost 20,000 employees (including nearly 2,000 health care workers) — indicates that with inflationary pressure and competition for talent, total compensation is a key pain point across the health care staffing landscape. This is compounded with childcare challenges, lack of advancement, insufficient onboarding, care model inefficiencies and several nonmonetary concerns at play.

How data can help drive retention

With four generations now occupying the workforce, building consistent and engaging employee experiences that address diverse key pain points is crucial. But for many of the health care leaders we speak with every day, measuring and truly comprehending employee sentiments can be daunting. To tackle workplace culture challenges, they need to leverage a strategic approach that includes the use of data analytics to better understand workers' frustrations. For example, collecting and analyzing more sophisticated employee inputs, including trade-off information on what employees value most, as well as behaviors to keep, start and stop to measure culture, are essential to drive better retention and productivity.

Many health systems are also going a step further by developing an integrated, end-to-end experience management ecosystem that gives leadership visibility into every phase of the employee lifecycle. Leading approaches include gathering operational interaction data around performance, taking explicit measures through tools such as surveys and feedback, tracking implicit metrics through social media and other channels, and performing deep-dive analyses and testing to uncover correlations between all of these data points. These efforts can drive growth and expand the business, boost employee productivity and goodwill, stem attrition and foster a deeper sense of belonging among employees.

What culture transformation looks like

Solving staffing challenges also requires health care leaders to leverage leading technology to drive key operational changes around employee grievances. And defining the organization's culture needs in terms of key behaviors is often the best place to start. For example, burnout often happens when workers are asked to perform tasks that are outside of their typical job role or not the best use of their time. This is where more clearly delineated career frameworks and job families developed through the use of analytics can make a tremendous difference.

Why finding the right mix of incentives is key

While compensation and benefits certainly aren't the only factors at play during the health care staffing crisis, health systems that overhaul their incentives even minimally will be best positioned to retain satisfied staff. For instance, one client conducting some research is finding that providing staff with support for student loans and tuition reimbursement, as well

as support for training of new managers, is expected to be a significant retention driver, even beyond base pay dollars. Others are exploring new options to support commuting and leaves of absence to care for children, parents or pets. In addition, many are providing flexibility as part of the mix for both caregivers and knowledge workers.

As they explore the right combination of benefits and rewards, health care leaders should consider that incentives such as sign-on bonuses, base pay increases, schedule flexibility, additional paid time off, and childcare and meal reimbursements aren't a one-size-fits-all proposition. Ensuring that the company has the right data to justify which of these package choices to offer is needed to provide the right mix to stem attrition.

How to move forward

Through a holistic approach to tackling the staffing crisis, health system leaders can blunt both the Great Resignation and the Great Reshuffle — and even address "quiet quitters" who may stay but are not satisfied — while building greater enterprise value in the process. Below are four key strategies to achieve these results:

1. Leverage leading technologies to understand the internal and external labor market and address what aspects of talent pressures are structural as opposed to cyclical. Take on workforce planning to lock in your organization's needed segment of the workforce.
2. Reimagine operating models with employee experience and satisfaction at the center.
3. Develop career frameworks, job families and other talent management solutions to mitigate burnout and ensure opportunities for promotion and progression.
4. Create a matrix of rewards trade-offs that are consistent with budgetary realities and employee preferences using market-research survey methods to gauge preferences and impact.

Summary

To succeed, health systems need to continue taking bold action to both blunt current attrition rates and attract new talent. The evidence-based, humans-at-the-center approach to defining future talent needs and overhauling culture and rewards described above is one of the best ways to achieve both and emerge stronger on the other side.

The views reflected in this article are those of the author and do not necessarily reflect the views of Ernst & Young LLP or other members of the global EY organization.

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The CDM - Leverage its Power to Drive Revenue and Compliance

Kyle Sherseth

by Kyle Sherseth

Hospitals continue to curb services in the wake of severe labor shortages as previously strong health systems report net losses and thin operating margins are becoming negative. In these uncertain times, providers are compelled to make agonizing cost cutting decisions while they tirelessly search for revenue optimization opportunities. The Healthcare Financial Management Association (HFMA) shed insight into one major source of revenue leakage when it reported up to 1% of net patient revenue is lost due to deficient charge capture processes. This, along with other charge-related optimization actions, present an opportunity to drive additional revenue.

While seemingly insignificant, a hospital's charge description master (CDM) is the very heart of an organization's revenue cycle, and its charges are the life blood whose flow commences with the recording of services that are converted into actionable data points, creating bills whose subsequent reimbursement enable the continuation of services that are recorded, and so the cycle continues. More than a data warehouse, the CDM records a patient's care, documents quality, facilitates federal and state reporting, determines resource allocation, supports budget decisions, and influences capital investment strategies. A high functioning CDM is key to a healthy bottom line.

Understanding the interdependence of financial stability and CDM viability does not necessarily equate to a commitment to quality maintenance of the database. In January 2022, InformationWeek reported 78% of healthcare executives identify charge capture as essential but only 40% discuss it at least once a month. This disconnect is alarming given the imperative to plug revenue leakage.

The need to shore up a sagging bottom line is evident. Conducting a comprehensive CDM assessment and then developing a well-designed maintenance program it is undoubtedly one of the best tools available to achieve improved financial performance. The American Academy of Professional Coders (AAPC) states that an effective CDM is compliant, correct, and complete. This recommendation is the foundation of a CDM review and the ongoing goal for maintenance.

Compliant CDM

A non-compliant CDM can spawn billing errors and overpayments. Overstated charges or inaccurate billing and coding increase the risk of audits and legal exposure. An out-of-date CDM may not comply with federal, state, and payor requirements. It can generate overcharging due to out-of-date incremental charging methodologies, noncompliance with approved or separately billable items, inappropriate automatic charging routines, or failure to update line items to reflect new devices.

These compliance issues increase the likelihood of audits. An Ingenious Med survey found 56% of surveyed healthcare providers said they have been audited more than once. Most respondents believe up to 20% of charges are either over or under-coded. Defending audits requires resources and time not readily available in this labor shortage environment. Audits result in payback, penalties, and increased scrutiny. CMS levies heavy fines and penalties for accepting overpayments on federal claims. A comprehensive CDM assessment mitigates the legal and financial risks associated with a non-compliant charging.

Correct CDM

A correct CDM reduces compliance risk, decreases cost-to-collect, improves timeliness of billing, and reduces denials.

A CDM assessment reviews each line item to ensure charges reflect accurate revenue codes, CPT/HCPCS codes, and modifiers. While updating a CDM quarterly based on CMS updates is necessary, other important ongoing changes can be overlooked. The CDM can contain deleted or non-billable CPT codes, charges coded with CPT rather than the appropriate HCPCS code, HCPCS codes that are unlisted or missing for recording separately paid drugs and missing or inaccurate modifiers.

Beyond line-item errors, a review of the CDM ensures established automatic processes designed to improve charge collection and efficiencies are working properly and remain accurate. Some of these processes include bundled charges,

automatic billing of certain common items, pharmacy charging, and assigning OR time increments. Improper bundling of items creates denials and can negatively impact revenue if done incorrectly. Daily charging of routine supplies frequently come under payor scrutiny and a more advantageous dispersion of these items should be considered. A faulty conversion of pharmacy dispensing units to billing units is a source of concern as is an obsolete or improper assigning of OR time units from the current process to a revised methodology.

Having an accurate CDM facilitates transparency and defensibility. A CDM review uncovers scenarios where the same service, delivered in a different setting, has a different fee. This common practice can trigger audits and creates patient confusion. Generally, if the resources required to deliver a service are not drastically different between departments, the charge amounts should be aligned. A CDM charge review can also uncover over and undercharging. The billing of separate services that should be bundled is overcharging and results in denials; bundling services that can be billed separately results in undercharging and lost revenue.

Complete CDM

A CDM can be compliant and accurate, but not complete. This database must capture all services rendered to patients. It is this record of care that is communicated to payors and regulatory agencies to generate reimbursement, rate-setting, and quality reporting. Failure to thoroughly charge for the full array of patient services is a costly mistake that erodes revenue and degrades a provider's potential profitability.

A CDM assessment includes interviews with all departments to review the services they provide, how these items are charged, and if the coding is correct. As part of the interview process, probing questions are asked to determine if additional services are being delivered that are missing from the CDM, if any services require charge modifications, or if the appropriate code for accurate reporting is not available. Workflows are reviewed and automatic charging scenarios are evaluated for accuracy and completeness.

In addition to newly identified services in a department, incomplete charging frequently occurs, especially in the operating room. Procedures change, new services are undertaken, and device assisted surgeries abound. All too often, these nuanced changes are not reflected in the CDM. Without the ability to charge accurately or completely, staff choose the CDM item closest in description or charge, resulting in poor documentation and possibly shortchanging the provider's reimbursement or creating compliance risk. This same situation occurs with the deficient maintenance of medical devices and implants with correct HCPCS coding in the CDM. Lost revenue, warranty and recall problems, and compliance issues arise from an inability to charge for every service documented in the patient's medical record.

CDM Maintenance Best Practices

Struggling with diminishing cash and competing priorities, a comprehensive CDM assessment is frequently relegated to a less significant status. Providers defend this position by declaring there have been no changes in services over the last few years, internal resources review the CDM on an annual basis, software is used to address this need, or charges do not matter in a predominantly DRG environment.

These positions are plausible but given the pivotal role the CDM holds in maintaining the financial viability of healthcare providers, this approach is imprudent. Best practice recommends an initial complete CDM assessment with quarterly update reviews to ensure and maintain a CDM that is compliant, correct, and complete.

In addition to departmental interviews and a full line-item review of charges, the comprehensive CDM review documents all processes to assist with education, facilitate changes, and support audits. A third-party review provides a unique perspective. By engaging a reputable vendor, the organization benefits from their in-depth experience with your specific EMR and PAS, including how items map between the two systems, bundling regimens, routine supply charging policies, and OR charging nuances. The vendor understands the geographic and payor specifics enabling them to recommend optimization strategies to strengthen a provider's price defensibility, enhance market share, and increase revenue.

The CDM drives the revenue cycle. As healthcare transitions from fee-for-service to value-based reimbursement, the ability to document the patient's history and full range of care is critical for assessing quality and ensuring revenue integrity. The CDM is the powerhouse supporting cost-recovery, reimbursement, price defensibility, and competitive market fees. It is not a set it and forget it exercise. Maintaining the CDM requires the consistent, ongoing effort of a dedicated and expert team. This process is essential for organizations to thrive in this ever changing healthcare environment.

About the author

Kyle Sherseth is Vice President of revenue cycle solutions and offers 14 years of experience in revenue integrity, payment validation, and CDM management. He lends his revenue cycle expertise to drive innovation within Savista's service lines and design charge integrity, denials, and AR offerings that maximize value for clients. Kyle previously led Savista's CDM advisory team that delivers CDM compliance, pricing, and maintenance support to clients. He holds a CHFP certification through HFMA and is a Price Transparency subject matter expert. Kyle can be reached at kyle.sherseth@savistarcm.com.

What's the Benchmark Observation Rate?

Ronald Hirsch

by Ronald Hirsch, MD, FACP, CHCQM, CHRI

Hardly a week goes by when I am asked either what a hospital's observation rate should be or what a hospital can do to lower their observation rate because it is felt to be "too high." So what is the right rate and is your rate too high?

First, you have to be sure you are comparing apples to apples. How is the observation rate determined in each institution? Observation is often a catch-all for all patients who are staying in the hospital but are not admitted as inpatient. In reality, observation is a specific service ordered on outpatients who require a period of monitoring in the hospital beyond the emergency department evaluation or after routine recovery from an outpatient surgery. Observation is not to be used for the routine recovery patient who spends the night in the hospital, for the patient who cannot get a ride home or for the patient that is dropped off by the family because they cannot take care of their loved one any longer.

The observation rate also depends on how it is calculated. Are patients who receive observation services but are subsequently admitted as inpatient counted in the rate? Is the rate the number of observation patients compared to all patients who spend a night in the hospital (inpatient and outpatient) or compared to all inpatients? Does the rate look solely at fee-for-service Medicare, where the observation rules are clear, or does it include Medicare Advantage and commercial patients, where the differentiation between observation and inpatient is often determined by contractual terms or at the whim of a reviewer who may be incentivized to deny as many inpatient admissions as possible?

Observation is also not always a bad thing. The current ambulatory payment classification (APC) for observation services provided to patients where the billing requirements are now pays $2,231 (C-APC 8011) and if observation services are provided efficiently with a minimum of incidental services provided, the reimbursement can exceed the actual costs of providing that care. Reimbursement for many of the lower weighed diagnosis-related groups (DRGs) barely exceeds that amount so it may be possible to make money on observation and lose money on inpatient admissions.

The Two Midnight Rule draws a bright line at two midnights. Patients in medically necessary hospitalizations should not pass two midnights without being admitted as inpatient. Many hospitals have not embraced this and keep patients in observation past the second midnight despite the presence of medical necessity for hospital care. These hospitals are losing the opportunity to convert an outpatient APC payment into a DRG payment.

Likewise, patients who are expected to require under two midnights should not be admitted as inpatient expect for the exceptions outlined by CMS in their guidance. Some hospitals have adopted the philosophy that the payment for observation services is inadequate and they therefore feel justified in admitting as inpatient patients who have passed two midnights due to convenience or social factors, rationalizing it by noting that the short stay inpatient admission audits are limited to patients whose length of stay is one midnight. That means these admissions will never be audited so no one will realize that the medically necessary portion of the admission was limited to one day. This is anathema to the concepts of compliance and should be avoided.

Because of the many variables in defining and measuring and observation rates, it is better to set a best practice policy and aim to meet or exceed that policy in order to achieve your hospital's benchmark observation rate. The best practice for observation services is the modestly named "Hirsch's Law," which states that if every patient requiring the use of a hospital bed is reviewed by case management for proper admission status, with the use of a secondary physician review as appropriate, and every patient is placed in the right status, and observation services are only ordered on the patients where observation services are appropriate per regulations, and every patient goes home as soon as their need for hospital care has finished and every patient who requires a medically necessary second midnight is admitted as inpatient, then your observation rate is at your benchmark.

How does one meet the requirements of Hirsch's Law? Adequate resources dedicated to utilization review are critical. The utilization review staff needs to be available when patients are presenting to the hospital for further care to assist physicians in making these decisions. Many hospitals provide full staffing on

weekdays but only have limited staff available on evenings and weekends. Unless the emergency department closes on Friday at 5 pm and reopens on Monday at 7 am, there needs to be UR staff available off hours. It should also be conveyed to physicians that these are purely payment issues so they do not get defensive and resist asking for help; they are not being told what antibiotic to choose or what specialist to consult.

Because it is felt that processes that cannot be measured cannot be managed, rather than comparing observation rates between hospitals and subjecting yourself to incorrect assumptions, there are several measures that can be used. First, as noted, keep your data clean by only looking at Medicare fee-for-service patients. Including other payers will taint your data depending on your payer mix and the rules used by the other payers, or lack thereof. Hospitals should also look at the length of stay for medical patients receiving observation services and work to optimize that. If you want to look at observation services after outpatient surgery, keep that data separate from medical observation; the two cannot be compared because of the fundamental difference in their care.

If you are going to compare your observation length of stay to other hospitals, be sure that they are not including observation provided routinely to patients after an outpatient procedure (often incorrectly used to enable the bed control system to assign the patient a bed for overnight use) or observation care provided as a courtesy. Likewise, your medically necessary observation hour counting and billing should end when medically necessary hospital care has ended. "Observation" care is by definition only care that is clinically appropriate. If a patient remains in the hospital for 4 hours or even overnight because of lack of transportation home, that care should be billed as HCPCS A9270 and not as observation hours.

Ensure that tests needed to determine an observation patient's stability for discharge, such as cardiac stress tests and magnetic resonance imaging (MRI), are prioritized over routine tests, that the physicians responsible for interpreting those tests, such as radiologists and cardiologists, are available when the tests are completed, and that the results are expeditiously relayed to the treating physician for a disposition decision. It would be relatively easy to break this down by diagnosis, service, day of week and physician to target quality improvement efforts.

Next, look at the number of patients receiving observation services who are hospitalized more than two midnights to determine if any of these had medical necessity for hospital care beyond the second midnight and therefore should have been admitted as inpatient. And finally take a close look at all inpatients who spend only one midnight to ensure that they truly met one of the specified exceptions and that the documentation supports that exception.

This deep dive into your data will provide you with accurate, measurable, and actionable information to ensure you are placing patients in the right status, optimally providing their care, receiving the reimbursement you deserve and avoiding a surprise visit by an auditor or the Inspector General.

About the author

Ronald Hirsch, MD is vice president of regulations and education for R1 RCM Inc. He is on the national advisory committee for the American College of Physician Advisors and the National Association of Healthcare Revenue Integrity and the co-author of The Hospital Guide to Contemporary Utilization Review. Dr. Hirsch can be reached at Hirsch@R1RCM.COM.

Wednesday, October 26th

Lunch	**12:00pm to 12:50pm**		**BallRoom**
General Session #1	**12:50pm to 1:40pm**	**(1 CPE)**	**BallRoom**
Current Event Update			
Michael McLafferty, MJM Advisory and Educational Services			
Networking Break	**1:40pm to 2:00pm**		**Vendor Hall**
Breakout #1	**2:00pm to 2:50pm**	**(1 CPE)**	
Healthcare Industry Tax Update 2022			**Room 1**
John Smith, Withum			
Navigating the storm. Keeping your revenue on course with disruption			**Room 2**
Jonathan Wiik, FinThrive			
Current Trends in Federal and State Fraud and Abuse Investigations			**Room 3**
Jack Wenik, Epstein, Becker and Green			
Transtion between Breakouts	**2:50pm to 3:00pm**		
Breakout #2	**3:00pm to 3:50pm**	**(1 CPE)**	
Weighing the benefits of participating in Value-Based Care (VBC) Programs			**Room 1**
Nicole Rosen, Acadia Professional			
Brian Kern, Acadia Professional			
Rethinking patient financial engagement under rapidly changing legislation			**Room 2**
Morgan Stacks, CarePayment			
Karen Friemoth, CarePayment			
Samantha Roberts, CarePayment			
Cybersecurity Threats - Prepare and Prevent			**Room 3**
Gerry Blass, ComplyAssistant			
Francois Bodhuin, Inspira Health			
Networking Break and Snack	**3:50pm to 4:10pm**		**Vendor Hall**
Breakout #3	**4:10pm to 5:00pm**	**(1 CPE)**	
Industry Disruptors to address Workforce Resource Shortages			**Room 1**
Sandra Pinette, KODEHealth			
Debra Jaeger, Lehigh Valley Health Network			
Jacqueline Bond, AtlantiCare			
Moving Through the Continuum of Care: Transition of Care for the Acute-Care Patient			**Room 2**
Valorie Clouse, BKD, LLP			
Leveraging New Technology and Analytics to Drive a Compliant Good Faith Estimate			**Room 3**
Govind Goyal, Panacea			
Charity Event	**6:00pm to 8:00pm**		**Vendor Hall**
Fundraiser for the Community Food Bank of New Jersey			
Reception with Halloween Flair // Please bring CASH, No credit cards accepted			

Thursday, October 27th

Buffet Breakfast	**8:00am**		**BallRoom**
Chapter Awards	**8:45am to 9:00am**		**BallRoom**
General Session #2	**9:00am to 9:50am**	**(1 CPE)**	**BallRoom**
Managing Interpersonal Conflict in these DEI-Focused Times			
Katrina Campbell, Relief International			
General Session #3	**9:50am to 10:40am**	**(1 CPE)**	**BallRoom**
Four Ways for Health Systems to Ahead in the Race for Talent			
Roselyn Feinsod, EY			
Julie Dumser, EY			
Networking Break & Snack	**10:40pm to 10:50pm**		**Vendor Hall**
General Session #4 - Keynote	**10:50am to 12:05pm**	**(1.5 CPE)**	**BallRoom**
Benchmarks and Key Performance Indicators - Proceed with Caution			
Ronald Hirsch, R1 RCM			
Buffet Lunch	**12:05pm to 1:05pm**		**BallRoom**
Breakout #4	**1:05pm to 1:55pm**	**(1 CPE)**	
Analytics - The Art of Decision Making			**Room 1**
John Nettuno, St Josephs Regional Medical Center			
Enterprise-wide Impact of Centralized Credentialing and Payer Delegation			**Room 2**
Anna Arutyunyan, symplr			
Belinda Doyle-Puglisi, RWJBarnabas Health			
The Federal Government is Taking Aim at PPP Loan and COVID Relief Payment Fraud: What ALL Healthcare Businesses That Received Pandemic Relief Funds Need to Know			**Room 3**
Jim Robertson, Greenbaum, Rowe, Smith & Davis LLP			
Optimizing Your Revenue Integrity Program: Objectives, Strategies, Staffing and Performance			**Room 4**
Caroline Znaniec, Protiviti, Inc.			
Transtion between Breakouts	**1:55pm to 2:00pm**		

Thursday, October 27th

Breakout #5	**2:00pm to 2:50pm**	**(1 CPE)**	
	Hot Topics in Reimbursement		**Room 1**
	Jesse Vo, Moss Adams		
	Kyle Pennington, Moss Adams		
	Patient Assistance & Health Equity: A $30B Revenue Cycle Opportunity		**Room 2**
	Cris Hartigan, Atlas Health		
	Nio Queiro, Atlas Health		
	Preparing for the unthinkable: How Doylestown Hospital developed a Business Continuity Plan and Tabletop Exercise for an extended outage		**Room 3**
	John Hueter, Digital Health Consulting, LLC		
	Rick Lang, Doylestown Health System		
	Gerry Blass, ComplyAssistant		
	Jim Cavanaugh, Executive Healthcare Consulting		
	How to Successfully Implement RPA & AI in the Revenue Cycle		**Room 4**
	Andrea Rivera, Jzanus, LTD		
Networking and Ice Cream Break	**2:50pm to 3:10pm**		**Vendor Hall**
Breakout #6	**3:10pm to 4:00pm**	**(1 CPE)**	
	Healthcare Consumerism and the Capital Markets		**Room 1**
	Mark Starr,CURAE		
	Alex Paraison, Banner Health System		
	The Psychology of Choice: How It Can Impact Patient Engagement and Satisfaction		**Room 2**
	Stephen Scott, AccessOne		
	Hot Topics in Billing Compliance		**Room 3**
	Robert Bacon, University Of Pennsylvania Health System		
	Harnessing the Power of Data to Effectively Support and Direct a Pandemic Response		**Room 4**
	Sean Hopkins, New Jersey Hospital Association		
	Amina Razanica, New Jersey Hospital Association		
Transtion between Breakouts	**4;00pm to 4:10pm**		
Breakout #7	**4:10pm to 5:00pm**	**(1 CPE)**	
	Physician Engagement to Align Transformation Efforts		**Room 1**
	Jo Surpin, Applied Medical Software, Inc		
	The No Surprises Act—Its Impact on Reimbursement and Its Interaction with State "Surprise Medical Bill" Laws		**Room 2**
	Thomas LaGreca, Callagy Law		
	340B Pharmacy Drugs Price Transparency Drug Manufacturers Current Challenges		**Room 3**
	Fatimah Muhammad, Saint Peter's University Hospital		
	The CDM - Leverage its Power to Drive Revenue and Compliance		**Room 4**
	Kyle Sherseth, Savista RCM		
President's Reception	**6:00pm to 8:00pm**		**Event Center, Ballroom C**
Late Night Dance Party	**10:00pm to 1:00am**		**Premier Night Club**

Friday, October 28th

Buffet Breakfast	**8:00am**		**BallRoom**
General Session #5	**9:00am to 9:50am**	**(1 CPE)**	**BallRoom**
	When Passion Meets Purpose		
	Reggie Hodges, Capio		
General Session #6 - Panel	**9:50am to 10:40am**	**(1 CPE)**	**BallRoom**
	Finding Perspective: Leaders discuss adapting to today's workforce		
	Mary Torretta, JD, Grant Thornton		
	Nick Barcellona, Temple University		
	Jessica Shure, Lehigh Valley Health Network		
	Eric Gonzaga, JD, Grant Thornton		
Break	**10:40pm to 10:50pm**		**BallRoom**
General Session #7 - Panel	**10:50am to 12:05pm**	**(1.5 CPE)**	**BallRoom**
	Forging a path to financial sustainability for hospitals and health systems: A panel discussion with hospital and health system CFOs		
	David Gregory, Baker Tilly		
	Gail Kosyla, (incoming) Yale New Haven Health		
	Garrick Stoldt, Saint Peter's Health System		
	Herb White, Hunterdon Healthcare		

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2022 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 2021–2022 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 2021–2022 Chapter Year.

The accompanying Balance Sheets and statements of Activities and Cash Flows for the years ended May 31, 2022, 2021 and 2020 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.

Respectfully submitted,

Stacey L Medeiros

Stacey Medeiros, MBA, FHFMA
2021-2022 Audit Committee Chair
NJ HFMA

Healthcare Financial Management Association - New Jersey Chapter
Balance Sheets

	May 31		
	2022	2021	2020
Assets			
Current Assets			
Bank accounts	$ 246,995	$ 254,663	$ 269,780
Accounts receivable, net	14,380	2,800	785
Other current assets	1,980	12,247	23,024
Total current assets	263,355	269,710	293,589
Investments	24,104	25,867	-
Fixed assets	-	-	-
Total assets	$ 287,459	$ 295,577	$ 293,589
Liabilities and net assets			
Liabilities			
Current liabilities			
Accounts payable	$ 168	$ 4,290	$ 1,921
Deferred revenue	2,500	14,646	15,188
Accrued payroll	5,684	1,957	2,042
Total current liabilities	8,352	20,893	19,151
Total liabilities	8,352	20,893	19,151
Net assets			
Net assets without restriction	279,107	274,684	274,438
Total liabilities and net assets	$ 287,459	$ 295,577	$ 293,589

Healthcare Financial Management Association - New Jersey Chapter
Statements of Activities

	Year ended May 31		
	2022	2021	2020
Income			
Meeting and education income	**106,638**	**675**	**167,167**
Newsletter income	**17,220**	**16,980**	**25,065**
Golf Outing Income	**55,475**	**35,690**	**-**
General sponsorship income	**188,289**	**77,781**	**183,129**
Interest income	**422**	**80**	**2,098**
Other income	**-**	**166**	**20**
Total income	**368,044**	**131,372**	**377,479**
Expenses			
Meeting and education expenses	**271,464**	**43,951**	**288,132**
Newsletter expenses	**14,239**	**18,286**	**25,154**
Golf Outing expenses	**30,896**	**26,900**	**297**
Member recognition and social event expenses	**6,899**	**2,070**	**3,379**
General and administration expenses	**39,133**	**40,227**	**61,626**
Provision for bad debts		**595**	**385**
Total expenses	**362,630**	**132,029**	**378,973**
Net Operating Gain/(Loss)	**5,414**	**(657)**	**(1,494)**
Unrealized gain and loss	**(1,991)**	**903**	**-**
Net income (loss)	**3,423**	**246**	**(1,494)**

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

	Year ended May 31		
	2022	2021	2020
Operating activities			
Net income (loss)	3,423	246	(1,494)
Adjustments to reconcile net income (loss) to net cash provided by (used in) operations:			
Change in unrealized gains (net)	1,991	(903)	-
Accounts receivable, net	(11,580)	-	16,475
Other current assets	10,267	-	(3,437)
Accounts payable	(4,122)	-	(56,612)
Deferred Revenue	(12,146)	-	(26,032)
Accrued Payroll	3,727	-	(2,428)
Net cash used in provided by (used in) operating activities	(8,441)	(657)	(73,528)
Cash flows from Investing Activities			
Purchases of Investment, net	(227)	903	-
Net decrease in cash	(8,668)	246	(73,528)
Cash at beginning of period	272,527	273,184	346,712
Cash at end of period	263,859	272,527	273,184

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Denials continue to be a problem for healthcare providers. According to Vyne Medical, through the third quarter of 2020, the average denial rate was up 23 percent since 2016. That could be as much as 3.3 percent of a typical health providers NPR, an average of $4.9 million per hospital. ***There's your extra cash!*** Revco has years of experience in appealing and collecting denials—inpatient, outpatient, administrative, and complex clinical. Our proprietary denials management software, robust follow up process, and professional negotiation skills yield results. Over the last several years we have recovered over $130 Million for hospital and physician groups in New Jersey. That money might have been written off and lost forever. Instead, it went right to our clients' bottom line. ***Just saying...***

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