hfma™
new jersey chapter

Early Fall 2022 • vol 68 • num 4

garden state focus

national excellence award winner

- YOUR PATH TO PROGRAM SUCCESS: EXPERT ADVICE
  Achieving Improved Financial Performance Must Involve Your Providers
- DOJ Enforcement Actions Alleging PPP Loan and Healthcare-Related COVID-19 Fraud Continue to Rise

focus •advertisers•

CBIZ KA Consulting Services, LLC

REVCO

Withum Smith+Brown

focus •cover•

Cover Courtesy of
Jennifer Lenahan

focus •points•

focus •features•

Who's Who in the Chapter 2021-2022

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

Communications Committee

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

NJ HFMA Chapter Officers

President, Brian Herdman.....CBIZ KA Consulting
President-Elect, Heather Stanisci ..... Arcadia Recovery Bureau
Treasurer, Maria Facciponti .....Elite Medical Receivables Solution
Assistant Treasurer, Hanna Hartnett.....AtlantiCare Regional Medical Center
Secretary, Jonathan Besler..... BESLER

NJ HFMA Board Members

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

NJ HFMA Advisory Council

Stacey Medeiros.....Penn Medicine
Michael McKeever..... Retired
Erica Waller ..... Penn Princeton
Jill Squiers.....AmeriHealth NJ

DEADLINE FOR SUBMISSION OF MATERIAL

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

IDENTIFICATION STATEMENT

Garden State "FOCUS" (ISSN#1078-7038; USPS #003-208) is published bimonthly by the New Jersey Chapter of the Healthcare Financial Management Association, c/o Elizabeth G. Litten, Esq., Fox Rothschild, LLP, 997 Lenox Drive, Building 3, Lawrenceville, NJ 08648-2311

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

OBJECTIVE

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

EDITORIAL POLICY

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

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

REPRINT POLICY

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

The President's View . . .

Brian Herdman

Dear Colleagues,

A new year rolls over in our small world of healthcare financial management; our many hundreds of members continue to push for a return to "normal" while clinging on the flexibility of the "new normal." The incremental, marginal change that is ever present in our industry gave way to a deluge of different. Our clinician peers bore the brunt of stress while the finance and reimbursement teams pushed for new ways to continue operations and protect the margin in healthcare that is vital to the mission of healthcare.

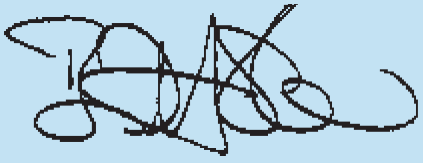
Just like working teams within providers and business partners have adapted to change, HFMA NJ will continue to adapt as we provide education and opportunities to connect with peers in our industry. Webinars and remote learning are here to stay, but these are no substitute for power of intellectual collisions when we gather to for updates on regulations or best practices and frankly discuss our challenges among peers.

The COVID-19 pandemic did nothing to alleviate the country's awareness of the growing cost of healthcare in the US. Tighter belts in corporate board rooms and in Capitols in DC and throughout the states will add to rate pressure. HFMA is reframing the Triple Aim (quality care, quality experiences, and lower cost of care) into the concept of Cost Effectiveness of Health. To be sure, quality and lower cost are still core to initiative; but Cost Effectiveness of Health extends to beyond patient interactions when someone is in poor health. Cost Effectiveness of Health strives to keep patients healthy though treating the whole-health of the patient, including social supports when needed. Cost Effectiveness of Health is not a measure of how well healthcare restores a patient's health – but a measure of how we keep a patient healthy out of the acute healthcare system.

To that end, David Crane, 2022-2023 HFMA National Chair, has chosen the theme "Ignite the Spark" for his term. David is a long-time resident of the Pacific Northwest, which has been devastated in recent years by forest fires. In his remarks to members at the Annual Conference, David reminded us that we are not doing enough to be good stewards of the land. By many estimations, we are not carefully planning and igniting the control fires that burn the underbrush and minimize uncontrolled spread, nor are we demanding the discipline required to limit the sources of ignition throughout the woodlands. David challenged us to look around our parts of the healthcare wilderness; to plan and ignite the spark that will improve the overall Cost Effectiveness of Health, even if we must bear the cost of helping that control file burn.

I look forward to hearing about the good work going on our industry as we respond to financial pressures, and the bold steps we are taking to ignite the spark that will a valuable foundation for the change to come.

Sincerely,
Brian Herdman



From The Editor . . .

Jill Squiers

As we lean into Fall with this Late Summer edition of the *Garden State Focus* I'm reminded of the many contributions the NJ HFMA community makes to support the Chapter and move our education forward. This past Spring the Chapter hosted its popular Women's Leadership & Development program after a two-year hiatus, and we also launched a new initiative: bringing information about NJ HFMA to New Jersey colleges so both the Chapter and students entering the workforce can benefit from the education and networking opportunities we offer.

The ideas presented at those two events are echoed within the pages of this Focus, among other timely topics. Linda Schwimmer, President and CEO of the New Jersey Health Care Quality Institute, served as moderator at the Women's event to lead a panel discussion reviewing the impact of social determinants of health, and this important issue is explored further here. And the potential for mentorships raised during our college outreach initiative is discussed, including the perspective from both mentor and mentee. Other topics include the importance of the hospital-professional provider relationship for financial performance; action by the US Department of Justice related to COVID-19 fraud; factors affecting hospitals' SSI percentage calculation; and the reduction of 340B discount programs by drug manufacturers. Chapter Past President John Dalton discussed whether we've turned the corner on COVID and closes with a retrospective on the many historical accomplishments of Past President Jack Farmer, who passed in May.

Also contained within these pages is the new Who's Who, the list of leaders volunteering their time and expertise for the Chapter year that began in June under Brian Herdman's stewardship. You'll see them soon when we all return to the Borgata for the upcoming Annual Institute, October 26-28!

LOOK NO FURTHER...

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...***

REVCO™ SOLUTIONS

Formerly Known as ARMC Financial Services, LLC

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

YOUR PATH TO PROGRAM SUCCESS: EXPERT ADVICE

Achieving Improved Financial Performance Must Involve Your Providers

Ryan Graver

by Ryan Graver

In this month's article, we speak to Peter L. Duffy, MD, MMM, FACC, FSCAI, who has spent the last 30 years not only honing his craft as an interventional cardiologist and treating coronary artery disease, but being a staunch advocate for the ways and means of how interventional cardiology can be delivered specific to quality and outcomes. As a board member of the Society for Cardiovascular Angiography and Interventions (SCAI), a leader within his practice and several hospital system cardiovascular service lines, Dr. Duffy also recognizes that the relationship between provider and hospital has taken on greater significance. He shares his observations and concerns with us as healthcare continues to evolve. It is for these reasons that he serves as a medical advisor to Terumo Health Outcomes to better help us chart a course and offer solutions for hospitals and providers.

— Gary Clifton, VP Care Pathways

Introduction

It has been said that in any service industry, there are three components that define delivery of that service: good, fast, and cheap — and that you can have only two of those options. U.S. healthcare is good and fast, but we are certainly not cheap. As our healthcare system continues to explore the means whereby we can deliver care more cost effectively, existing examples can show us how to scale a more cost-effective system through increasing attention to quality, outcomes, and risk.

Over the past decade, U.S. hospitals determined that a viable solution to manage cost pressures was by controlling those who were responsible for generating costs, i.e., providers. As a result, we saw a steady and significant effort to purchase physician practices; specifically, cardiology as a subspecialty was targeted in these efforts. However, the reality is that system costs did not go down, profitability largely did not improve, length of stay stayed flat, readmissions continued, and both the total cost of care to payers and out-of-pocket expenses for patients continued to rise. Why didn't we see sweeping cost improvement driven by the major roll-up of provider practices by hospitals? It can largely be attributed to the simple fact that the employment of providers by hospitals does not address the perversely aligned incentives that inherently exist in our system.

In our last article[1], we discussed the multiple references from

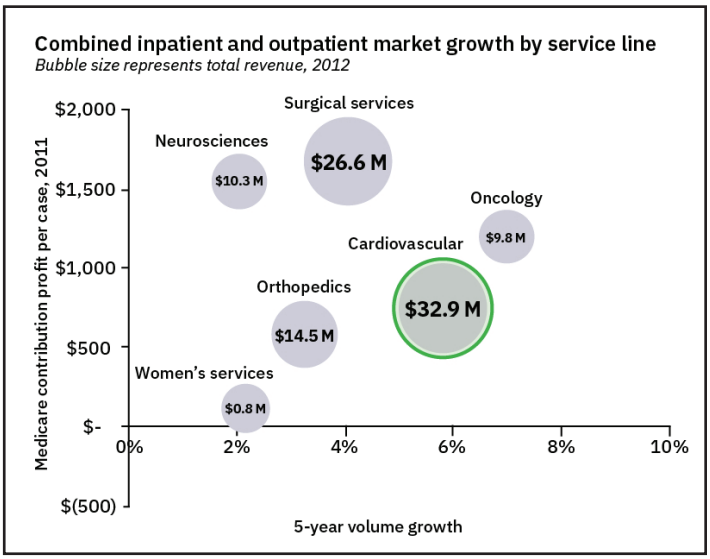


Figure 1. These data, from the Advisory Board's State of Our Service Lines analysis, show that in 2011-2012, cardiovascular service lines were the largest contributor to hospital profit and the second-fastest growing service line. Reprinted with permission from the Advisory Board.[2]

the Center for Medicare & Medicaid Innovation (CMMI) and Centers for Medicare & Medicaid (CMS) referring to mandatory bundled payment programs, and the impact that quality, outcomes, and operational efficiency have on the bottom line of any program. We are excited to share Dr. Duffy's insights and perspective on what all this really means to a cardiologist, and why those in the healthcare field should be preparing for and taking action to position themselves successfully for what's next.

Dr. Duffy, in our last article[1], we discussed changing payment models. Can you help articulate why cardiologists, now more than ever, should pay attention to these types of proposed changes?

It is often said that the practice of medicine is an art, but the delivery of healthcare is a business. While we as cardiologists focus on patient care and derive great satisfaction from applying our clinical training and expertise, enjoy interacting with our colleagues and support staff, and find great reward in bringing hope and improvement in the quality of life to our patients, we must recognize that our compensation is dependent upon our business model and not on just the incredible work that we do.

To that end, it is important that every cardiologist understand just where his or her compensation is coming from. For employed physicians, it is driven by profits generated from the services provided in the care of cardiovascular patients. The vast majority of payment to the hospital is in the form of reimbursement for the technical fees and ancillary services associated with the services we provide. The remainder of that amount, usually less than 20%, goes to the hospital system for physician compensation. At the present time, cardiovascular services are in the enviable position of contributing a significant portion of the hospital's profit. That is because cardiovascular services are highly reimbursed, not because of the complexity of the procedures we perform. Medicare utilizes a cost-based system to assign reimbursement and this has led to cardiovascular care representing the single largest subspecialty spend to Medicare. As a result, Medicare and other third-party payers have these payments under a microscope. They have been working overtime for years to decrease the volume of the services we provide and are constantly working to chip away at reimbursement for our services, regardless of how complex or high-risk those procedures are.

Hospitals and cardiologists need to understand that physician compensation is not tied to the fact that cardiologists are associated with a highly recognized disease state, dealing with life and death decisions daily. The issue is that the cardiology service line is the highest revenue-generating service line in the majority of hospitals. The lost opportunity is not aligning physician and hospital goals, and incentivizing hospitals and physicians to work together to enhance the contribution margin from the cardiovascular service line. Reducing complications, reducing length of stay, and managing risks are the means to increasing contribution margins, and cardiologists need to be part of the solution. The bubble chart in Figure 1 shows how hospitals typically prioritize service lines. These data, from the Advisory Board's State of Our Service Lines analysis[2], show that in 2011 to 2012, cardiovascular service lines were the largest contributor to hospital profit and the second-fastest growing service line. As providers, we must understand this is the main driver of why we have been compensated much higher than other subspecialties for more than the last decade and we must ask ourselves, is this simply going to continue, or do we need to take action?

If a cardiologist's compensation has been driven by both the high impact of cardiovascular service line profitability and growth over the last ten years, what do you forecast for the next ten years?

We have seen a flattening and gradual decline in cath lab volume over the past several years. The number of elective percutaneous coronary interventions (PCIs) is decreasing and we will continue to see a decline in the number of patients going to the cath lab for acute coronary syndromes, given the increased effectiveness of medical therapy and even, to some extent, lifestyle modification. Return to the cath lab to treat in-stent restenosis appears to be at a lower level than ever. Growth will be in the area of structural heart disease, but once these procedures also become commoditized, they will be even greater targets than they are now for reimbursement reduction. Profitability for the system relies on two factors: the income to the system and the cost of the system to obtain that income. While income to the system may flatten or decline, and is driven mainly by set Medicare fees, contract negotiation, and volume; much of profitability is driven by cost. Systems that continue to have high cost will have less profit from their service lines and this is clearly an area where involved and integrated cardiologists can play a major role.

Going forward, it is important for cardiologists who want to protect their standard of living — and I think that would include all of us, employed and independent — to be

familiar with how our hospital system is being compensated for our services and develop ways to work in alignment with our hospital systems to maximize their profit. Essentially, if the profits derived from the cardiovascular service line decline, there is every reason to believe that hospital administrators will offset those declining profits by lower compensation to the physicians providing cardiovascular services. Aligning with hospital goals does not mean increasing the volume of unnecessary procedures. Many studies have shown this actually increases the cost to the system and ultimately, can decrease profitability. Rather, cardiologists must look at the overall structure of how cardiovascular care is delivered in their institution, and work with system administrators and managers to ensure that the care that they are providing is not only appropriate, but that it is efficient, effective, equitable, patient-centered, safe, and timely.

Cardiologists are in the best position to lead their healthcare systems in reaching the goal of achieving the Quadruple Aim: better outcomes, lower costs, improved clinician experience, and improved patient experience.

Cardiologists are in the best position to lead their healthcare systems in reaching the goal of achieving the Quadruple Aim: better outcomes, lower costs, improved clinician experience, and improved patient experience. Cardiologists who go beyond being employed by healthcare systems, who are aligned and focused on helping their system reach defined strategic goals, will be in the best position to realize the benefit that achieving these goals will bring to the hospital's profit margin. Doing so will maintain cardiovascular services as a high-percentage contributor to that margin, thus enabling cardiologists to continue to maintain and enjoy the high compensation levels currently earned. Cardiologists who simply remain employees will be at the mercy of their system and easy targets for compensation reduction when profits fall due to poor quality, inefficient processes, and continued waste of valuable resources.

Can you provide an example of where cardiologists could contribute to reducing costs and improving efficiencies, and impact patient outcomes/experience?

Perfecting the same-day discharge process for PCI is a prime opportunity for optimizing resource utilization that virtually no organization has mastered. An ideal process in this regard includes identifying patients eligible for same-day discharge before they are scheduled, coordinating with the scheduler to ensure that those patients are placed in early day slots, and that those eligible patients are then screened for same-day discharge after the procedure as well. The percent of patients who meet both pre and post criteria for same-day discharge and are actually discharged should be tracked (ideally 100%), and reasons for failure to meet the target identified and addressed in a timely manner. Less efficient organizations may meet the target, but only by extending staff hours in the post PCI or holding area beyond the regular closing time. This is costly and wasteful, and can decrease staff satisfaction. Other organizations have same-day discharge processes, but are not utilizing them effectively. These organizations have the most potential for process improvement and will benefit the most from partnering with their cardiologists. The least efficient organizations have no process at all. This is clearly an area where cardiologists can be instrumental in improving efficiency, optimizing resource utilization, and maximizing the contribution margin from the cardiovascular service line, while also enhancing the patient experience and maintaining excellent outcomes.

Given the fact that cardiologists have such direct impact on quality, outcomes, and efficiencies, I am wondering if in all your years of practice, has a hospital ever shared your financial contribution to the service line with you and discussed how it could be improved upon?

One of the biggest obstacles all cardiologists (and even service line leaders) have is getting a clear understanding of the finances of the service line. To be fair, part of this is because the costs related to each unique patient's services are often aggregated and thus make these costs somewhat difficult to assign. Additionally, individual systems have unique ways of allocating cost and income, making it difficult to do cross comparisons between systems. However, the fact is that even when such information is available, systems are often reluctant to share it with their cardiologists. For hospital systems to achieve the maximum potential of an ethical and highly profitable service line, administrators will have to rethink this approach and trust their cardiologists by transparently sharing all financial data in this regard. Administrators must also be willing to change their financial assumptions and projections when valid concerns are raised.

All physicians believe that they deliver the absolute best care to achieve the best outcomes, but how do we explain medical errors, complications, and delays in care?

All of these are an inevitable part of the practice of medicine. Every cardiologist wants to avoid all three. Minimizing the chance of any of these occurring requires clinical acumen, extensive training, expert technique, and attention to detail in a system that is designed for success. Appropriate patient selection, understanding and reducing patient risk, and tracking patient outcomes and complications and learning from them, is critical in this regard. As a cardiovascular

Perfecting the same-day discharge process for PCI is a prime opportunity for optimizing resource utilization that virtually no organization has mastered.

community, we have led the way in medicine by submitting data to registries where we can track and benchmark our performance. Unfortunately, there are many situations where these data are not shared with the cardiologists or if they are shared, the data are discounted and dismissed by the provider. All too often, we minimize things like acute kidney injury (AKI) or readmission, and say, "those numbers just aren't reported correctly", "it really doesn't matter", or "I don't see that in my patients." As physicians, we pride ourselves on being data driven and outcome focused. Are we really?

Quality needs to be built into our delivery systems. We should receive continuous and constant feedback, and the results should be funneled into our daily routine to optimize future procedures. Platforms like ePRISM that are integrated into our clinical workflow and that link to the American College of Cardiology's National Cardiovascular Data Registry (NCDR) risk algorithms represent a significant step for providers to take control of the quality of the care they provide.

What would you recommend to your colleagues to position them for success and to protect their incomes moving forward?

Unfortunately, COVID has exposed many issues in the U.S. healthcare system. An analysis conducted by Kaufman, Hall & Associates, LLC for the American Hospital Association[3] showed significantly higher expenses for labor, drugs, and supplies, and continued delay of care, all of which is negatively impacting the financial performance of hospitals and health systems through 2021. The report projected that hospitals nationwide would lose an estimated $54 billion in net income over the course of the year, even after taking into account federal Coronavirus Aid, Relief, and Economic Security (CARES) Act funding from 2020. The analysis projects median hospital margins to be 11% below pre-pandemic levels and more than a third of hospitals are expected to end 2021 with negative margins.

Couple the impact COVID is having with the out-migration of cardiovascular cases and the threat of mandatory downside risk programs; the financial outlook in healthcare is frightening. As we move through 2022 and beyond, cardiologists can certainly expect their income levels to be challenged. So, I would call on all of my colleagues to get engaged in driving the strategy and own the results. Whether employed by a health system or as independent providers, we can partner with our hospitals through co-management agreements and other mechanisms, but we need to take ownership. We also must shift our focus away from the old strategy of "just grow volumes." Unfortunately, increasing volume is not a good strategy for increasing profits and simply focusing on cost cutting is equally poor. Cost cutting in most systems usually means pressing suppliers for lower prices for their products and cutting staff hours, pay, or benefits. None of these are good long-term solutions to increasing the profitability of the hospital. The critical component, and why as providers we are key to driving change, is not cost-cutting, but the optimization of resource utilization. Optimization of resource utilization targets includes efforts to enhance efficiency and reduced waste. Examples include on-time starts, case turnover, driving same-day discharges, and improving quality to optimize length of stay, and in all of these, providers are critical to achieving and sustaining high-level performance.

Conclusion

Dr. Duffy, we thank you for agreeing to participate in this interview and for the incredibly important insights you shared from your experience. Entering 2022, our industry is clearly at a significant point. As you pointed out, with COVID impacting procedure volumes and staffing shortages driving up costs, the focus on achieving financial sustainability is likely to reach a fever pitch. It is hard to stress strongly enough just how imperative it will be for cardiologists and hospitals to find solutions that not only deliver the best quality-driven outcomes for the patient, but that are also cost effective for the hospital. Achieving these goals will require administrators and physicians to have the necessary data and metrics to substantiate performance improvements that in turn will ensure hospital and providers are achieving financial success.

Terumo Health Outcomes has accessed multiple benchmarking tools and analyzed every hospital's Medicare claims data in the United States in order to amass a reference on cost, quality, and cardiovascular service line financial performance.

If cardiologists are interested in comparing how their hospital performance stacks up against others and would like to learn about the solutions that Terumo can offer to help providers and hospitals achieve optimized performance, please contact us at **info@terumohealthoutcomes.com**. Our team is uniquely qualified to help physicians and hospitals address how and what is necessary to address the changing landscape. Our solutions are data-driven, seek to avoid cost, and are clinically focused.

References

[1]Graver R. Worried about revenue and growth? It's only going to get harder. *Cath Lab Digest.* 2021 Dec; 29(12): 30-32. Available online at https://www.hmpgloballearningnetwork.

continued on page 10

continued from page 9

com/site/cathlab/worried-about-revenue-and-growth-its-only-going-get-harder

[2]Advisory Board. The state of our service lines. 2018. Accessed January 17, 2022. Available online at https://www.eua.com/media/7922/eppstein_uhen_state-of-our-service-lines-handout.pdf

[3]American Hospital Association 2022 Health Care Talent Scan. Accessed January 4, 2022. Available online at https://www.aha.org/aha-talent-scan

Peter L. Duffy, MD, MMM, FACC, FSCAI

Ryan Graver
Divisional Vice President, Terumo Health Outcomes

What's In Your Beach Bag?

NJ HFMA Members share their personal and professional reading picks

Cheryl Cohen recommends **'The Storyteller'** by Jody Picoult.

"I found it excellent. It is about the persecution of Jews in Hitler era. It is the story of one particular woman, and what she experienced.

It is also about retribution.

The book is based on factual circumstances, but is fiction."

Betsy Weiss recommends **"Suburban Dicks"** by Fabian Nicieza

This was a fun read especially if you like murder mysteries and are familiar with the Greater Princeton area. It is the debut novel of a local author who was the co-creator of Marvel's Deadpool. As someone who resides in this community, what made this book relatable were the local references. For example, the murder of a gas station attendant takes place at the Valero station on Rte. 571 in West Windsor. Many scenes take place at local landmarks such as the Princeton Junction train station and Wegmans in Nassau Park to name a few. There is a strong element of satire and sarcasm applied to this particular suburban community which keeps it entertaining, all while addressing underlying deeper social issues of prejudice and racism.

CBIZ

CBIZ
KA Consulting
Services, LLC

CBIZ = PARTNERS

For over 40 years CBIZ KA Consulting Services, LLC has partnered with Health Care providers to deliver innovative solutions for:

Enhancing Revenue

The scrutiny on hospital and healthcare organizations' profit margins makes it more important than ever for your organization to capture appropriate revenue.

Ensuring Compliance

CBIZ's coding and compliance services look at coding and clinical documentation to ensure medical necessity and that services are coded and billed correctly.

Improving Medicaid Eligibility

CBIZ has been a trusted resource in assisting healthcare organizations to increase Medicaid enrollments.

Contact us today to learn more
www.kaconsults.com

CBIZ KA Consulting Services, LLC | 1-800-957-6900 |

DOJ Enforcement Actions Alleging PPP Loan and Healthcare-Related COVID-19 Fraud Continue to Rise

Christopher D. Adams

Robert B. Hille

Rachel A. Frost

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

In May 2021, U.S. Attorney General Merrick 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. The DOJ's efforts have led to investigations and prosecutions involving Paycheck Protection Program (PPP) fraud as well as healthcare-related COVID-19 fraud. The prevalence of pandemic-related relief fraud has been known for some time, but the extent and implications of such fraud are only now becoming clear.

Background

During the beginning of the COVID-19 pandemic, the PPP was established under the The Coronavirus Aid, Relief, and Economic Security Act (CARES Act) and implemented by the Small Business Administration (SBA) to keep small businesses and other organizations afloat. As it relates to PPP fraud, the DOJ has recently affirmed that the federal government will continue to persistently pursue fraud related to the PPP, the total of which is estimated to be as high as $80 billion. In late March 2022, the DOJ stated that only 178 individuals nationwide had been convicted in PPP fraud cases to date, however the government signaled that many more prosecutions are coming, making these initial convictions the tip of the iceberg. Federal prosecutors are calling this theft of taxpayer money intended to help those harmed by the coronavirus pandemic "the largest fraud in U.S. history" as it represents approximately 10 percent of the $800 billion handed out to small businesses in low-interest uncollateralized loans from April 3, 2020, through May 31, 2021.

Due to the urgency caused by the pandemic's impacts on the business sector, the need to dispense this important worker relief came at the sacrifice of instituting a more stringent applicant vetting process. Although many businesses and individuals benefitted by using their relief payments as intended, this fast-tracked process led to a relaxation of internal controls that also, in turn, increased the risk of PPP fraud. While PPP relief was designed to provide an incentive to keep workers employed, far too many business owners instead pocketed the money or misappropriated the funds to buy personal items, luxury goods, and vacation properties. For example, federal prosecutors have targeted individuals who used their PPP loan funds to pay for luxury purchases including hotel stays, automobiles, jewelry, and clothing. Most recently, in May 2022 in the Eastern District of North Carolina, a lawyer pled guilty and was ordered to forfeit over $2 million as a result of being involved in a fraudulent assistance loans scheme that funded her plastic surgery and several vacation homes, including one in Miami.

DOJ Enforcement Actions on the Healthcare Front

Today, the list of DOJ investigations and prosecutions are not just limited to misuse of PPP loans and PPP loan fraud schemes. By way of a nationwide law enforcement effort aimed to hold individuals accountable and to deter more of the same, the DOJ is looking to cast a wide net around what it sees as

healthcare-related COVID-19 fraud. Kevin Chambers, Director for COVID-19 enforcement for the DOJ, has described such coordinated efforts as "extraordinary" with the purpose being "to prosecute some of the largest and most-wide ranging pandemic frauds detected to date."

At this writing, nearly two dozen defendants from across the United States have been charged for their alleged participation in such schemes. Federal law enforcement agencies that are involved include the Federal Bureau of Investigations, Department of Homeland Security; Department of Health and Human Services Office of the Inspector General, Food and Drug Administration Office of Criminal Investigations; and the Postal Inspection Service

The subjects and targets of healthcare-related COVID-19 fraud cases vary from alleged bogus telemedicine encounters, to falsifying COVID-19 vaccination cards, to misuse of relief funds – and from medical professionals to manufacturers and distributors, respectively. For example, in a case out of the Southern District of Florida, a medical professional was charged with healthcare fraud for allegedly billing bogus telemedicine encounters that did not legitimately occur during the pandemic. In another case out of the Northern District of California, a pharmacy director was accused of using actual vaccine lot numbers to falsify COVID-19 vaccination cards. In yet another case out of the District of New Jersey, a Postal Service employee was charged with conspiracy for allegedly participating in a scheme to distribute fraudulent COVID-19 vaccination record cards to unvaccinated people. Most recently, in the Middle District of Pennsylvania, an individual was charged with knowingly creating and possessing an unauthorized COVID-19 vaccination card, which bore an official government insignia

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. For example, earlier this month in the Northern District of California, an individual who owned and operated healthcare and hospice companies pleaded guilty to theft of government property because of his misuse of PRF monies. In that case, the individual misappropriated nearly $200,000 worth of allocated PRF monies for personal use rather than for its intended purpose – to ensure continued relief and access to medical care. Moreover, the Center for Program Integrity, as a part of the Centers for Medicare & Medicaid Services (CPI/CMS), has taken corresponding administrative actions against medical providers accused of such alleged wrongdoings.

Key Takeaways

As demonstrated above, law enforcement actions are being brought more frequently and are extensive in scope. During the DOJ's pursuit of PPP fraud prosecutions, it may become challenging for the government to discern between borrowers that intended and affirmatively acted to commit fraud and those that were well-intentioned but nonetheless failed to comply with this fast-tracked federal relief program. As a result, many unwitting borrowers may find themselves caught in the DOJ's fishnet of fraud charges. 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 keep careful track of their billing practices, including billing for telemedicine, and institute safeguards to ensure COVID-19 relief funds are not being intentionally or negligently misused.

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 agency.

About the Authors

Christopher D. Adams is a partner and chair of the Criminal Defense & Regulatory Compliance Practice Group at Greenbaum, Rowe, Smith & Davis LLP, where he concentrates his practice in the areas of criminal defense, internal investigations, attorney ethics matters and disciplinary proceedings, and complex commercial litigation. He can be reached at 732.476.2692 or by email at cadams@greenbaumlaw.com.

Robert B. Hille is a partner in the firm's Litigation and Healthcare Departments, with white-collar experience encom-passing both state and federal investigations, including those related to healthcare fraud and abuse and the taking of fraudulent payments from government entities. He can be reached at 973.577.1808 or by email at rhille@greenbaumlaw.com.

Rachel A. Frost is an associate at the firm, where she concentrates her practice in the areas of commercial and healthcare litigation, criminal defense, internal investigations, and regulatory compliance. She can be reached at 732.476.2470 or by email at rfrost@greenbaumlaw.com.

How to Determine the Benefit of an SSI Percentage Recalculation

by Michael Newell

Michael Newell

As a primary component of Medicare Disproportionate Share Hospital (DSH) reimbursement, a hospital's Supplemental Security Income (SSI) percentage plays a significant role in determining the reimbursement impact.

Hospitals should research annually whether their facility could benefit from an SSI percentage recalculation, also known as an SSI recalculation, realignment, or redetermination. If this hasn't been historically or consistently reviewed, it's recommended that hospitals perform a look back through their SSI data.

What is the SSI Fraction?

Also referred to as the Medicare fraction of the Medicare DSH calculation, the SSI fraction represents the percent of patient days for beneficiaries who are eligible for both Medicare Part A and Part C and SSI.

By default, SSI fractions are based on the federal fiscal year (FFY) end—October 1 to September 30—and are generally published annually by the Centers for Medicare & Medicaid Services (CMS).

This concept makes sense for providers whose cost reporting period mirrors the federal fiscal year, but what about providers with cost reporting periods that differ from the September 30 FFY end?

Current CMS regulations allow a hospital to request its Medicare fraction or SSI ratio be recalculated or realigned based on the hospital's cost reporting period when it's different from the federal fiscal year.

In practice, if a hospital's fiscal year-end is December 31, 2018, the September 30, 2018, SSI ratio would be used in the Medicare Disproportionate Share calculation. According to the CMS regulations mentioned above, the SSI ratio could be recalculated to mirror the hospital's fiscal year beginning on January 1, 2018, and ending December 31, 2018, by using a combination of two federal fiscal years of the Medicare Provider Analysis and Review (MedPAR) file.

Both the September 30, 2018, and the September 30, 2019, SSI ratio data would need to be analyzed to determine the hospital fiscal year SSI ratio. The 2019 SSI ratio data was published by CMS back in November 2021.

Determining Benefit

It's a common misconception that stakeholders can attempt to estimate if they benefit from an SSI ratio redetermination by identifying provider fiscal years where their SSI percentage increased year over year. However, patient-level detail must be obtained and analyzed to accurately calculate and prepare a request for an SSI percentage redetermination from federal fiscal year to hospital fiscal year.

Once requested, hospitals must use the recalculated SSI percentage for the requested fiscal year. If a redetermination isn't analyzed properly, it could actually harm the hospital by decreasing reimbursement.

Data Required

CMS mines SSI patient detail data from MedPAR—a maintained record set that contains inpatient prospective payment system (IPPS) billing records for all Medicare beneficiaries who received inpatient hospital services. It's this patient detail that should be analyzed to properly determine the effects of a redetermination.

Let's establish another quick example. Hospital A's fiscal year-end is June 30, 2018. Traditionally, the September 30, 2017, SSI percentage would be used in the Medicare DSH calculation. However, since CMS regulations allow for an SSI redetermination, a recalculated SSI percentage would use a combination of data from the September 30, 2017, and September 30, 2018, routine use files that cover the months included in the hospital's cost reporting year.

Data Analysis

While the concept of requesting an SSI percentage redetermination seems fairly simple, hospitals should be aware the process contains many steps including data reconciliation. Verification of the published SSI percentage is always a recommended first step which can be accomplished by reconciling the routine-use, patient-level data.

When reviewing the routine-use data, providers should also be aware of the potential impact of Medicare Advantage days; the *Allina Health Services v. Sebelius decision* of the Supreme Court of the United States could have implications on what data should ultimately be included in your SSI percentage.

These are just a couple of data scrubbing procedures that must be completed prior to requesting an SSI redetermination. After all data scrubbing measures are performed, if your recalculated SSI percentage is found to be higher than the CMS-published SSI percentage for your hospital and fiscal year, then you could benefit from a recalculation and should prepare a redetermination request.

About the author

Michael Newell is Partner, Health Care Consulting with Moss Adams. He has worked in health care financial management since 1982. Michael can be reached at michael.newell@mossadams.com.

The Impact of 340B Drug Discount Restrictions

Fatimah Muhammad

by Fatimah Muhammad

340B Discount Restrictions

Recent studies show that drugmakers cutting 340B discounts reported record revenues for the financial period ending 31st December 2021 (340B Health, 2022). Notably, these drug manufacturers, which include some of the largest drugmakers, including Pfizer and AbbVie, started implementing 340B discount cuts negatively impacting the financial performance of the safety net hospitals. These manufacturer disputes span back to summer 2020. Accordingly, the drug makers continue to report increased profits with the report by 340B Health (2022) noting that collectively, the firms reported high revenues of more than half-trillion dollars. However, despite the numerous profits, of concern is the fact that as more drug makers – including the 18 drug manufacturers at the time of this writing – continue to cut the 340 discounts, the covered hospitals experience big financial losses, with some of the cuts affecting entities on the verge of closure.

Drugmakers/manufacturers Restricting 340B Discounts

AbbVie
Amgen
AstraZeneca
Boehringer Ingelheim
Eli Lilly
Merck
Novartis
Novo Nordisk
Sanofi
UCB
United Therapeutics
Bristol Myers Squibb
Pfizer
GlaxoSmithKline
Gilead
Johnson and Johnson
Bausch Health
Exelixis

The 340B program was enacted three decades ago and mandates drug companies intending to participate in Medicaid and Medicare's drug benefit to extend substantial discounts for eligible drugs participating healthcare facilities (Pifer, 2022). The role of the program is to help the government stretch its resources as far as possible to reach more patients, particularly the financially vulnerable members of the community. In exchange for the 340B discounts, hospitals are supposed to offer extra incentives to the low-income earners and ensure all patients receive adequate care. For instance, according to Community Oncology Alliance (2021), the average discount is 34.7% relative to the standard commercial prices. Cutting the discounts has a significant effect on hospital finances. Pifer (2022) noted that most of the urban hospitals reported approximately $2.2 million losses from the restrictions and a tenth of them expect the losses to exceed $21 a year. Critical access hospitals are also reporting more than $440,000 losses annually due to the restrictions. The higher bills resulting from the cuts and the subsequent delays are further worsening the health outcomes of the patients.

However, the drug manufacturers have continued to criticize the program noting that it does not offer appropriate mechanisms to ensure transparency yet they bear highest cost burden. As per the current structure of the program, most of the costs of the program are borne by drug manufacturers, while the financial benefits are accruing mostly to eligible hospitals, clinics and patients. In 2021 research by Community Oncology Alliance (2021) established that there is an aggressive effort by hospitals to leverage their 340B status by directing patients using high-profits drugs to the program. Further, hospitals benefit from the discounts even whey they are treating fully insured patients yet low-income patients treated from non-eligible facilities do not benefit. It has been a concern that not all participating hospitals account to how they use their

savings. As a result, some of the hospitals and clinics benefit from reduced prices at the expense of the manufacturer.

Manufacturers have not been very fond of providing revenue for 340B discounts and these restrictions are increasing expeditiously. It is no doubt that manufacturers underestimated the expansion of the 340B drug program and believe that patients aren't benefiting from the program, hence manufacturers believe that safety-net hospitals lack oversight of 340B Programs. Increased financial burden on manufacturers due to the increase in number of drugs used in the program are some of the primary reasons for the imposed restrictions on 340 drug discounts. The restrictions are in form of refusal to offer drugs to contract pharmacies in hospitals that had their own in-house pharmacy, requirement for more detailed reporting from the healthcare facilities to ensure there is no duplicate discounts, and to show that the beneficiaries are using the savings to help low-income patients (Bailey, 2022). As a result of the restrictions, the critical access hospitals have lost 39 percent of their critical savings (Bailey, 2022). The reported losses show that the savings generated from the discounts are critical to the survival of the hospitals.

The contradictory financial implications of drug manufacturers and healthcare facilities eligible for the 340B discount program imply that the program is not mutually beneficial. The government initiated 340B health program is supposed to benefit the vulnerable members of the community by reducing the prices of drugs and giving hospitals extra incentives to improve access to healthcare. The studies show the drug makers are reporting higher profits after cutting the discounts while the hospitals and clinics continue to record significant financial losses. Although the regulators are terming the move by the drug makers as unlawful, the fact that they bear most of the cost shows that it is upon the hospitals and the government to persuade by improving the provisions of the program. The manufacturers want the government to enhance oversight so that the benefits are passed to the intended target, vulnerable patients (Jane & Emily, 2021). Increased transparency by the benefitting hospitals through detailed financial reports showing how the funds are used and ensuring that savings are only used to benefit the members of the community. The hospitals and other benefitting healthcare facilities, and the patients are the main losers in the continuing restrictions on discounts by the manufacturers. As more manufacturers withdraw from the program, so do the hospitals lose through increased financial costs and subsequent losses. On the other hand, the drug makers report high profits. The effectiveness of the program depends on the ability of the main players, drug makers, hospitals, and the government to come to agreeable agreement. As for hospitals that lack transparency with their 340B program, they should adhere to the provisions of the program and increase their level of transparency so that they manufacturers can continue to offer the discounts. Safety-net hospitals are fearful that if these manufacturer restrictions become permanent, more than three-quarters of entities will result in cuts in healthcare services, patient support programs, and limitations for patient accessibility.

References

Bailey, V. 2022. Safety-net hospitals see losses from 340B drug discount limits. *Revcycle Intelligence*. https://revcycleintelligence.com/news/safety-net-hospitals-see-losses-from-340b-drug-discount-limits

Community Oncology Alliance. (2021). Examining hospital price transparency, drug profits, and the 340B program. *Community Oncology Alliance*. https://communityoncology.org/featured/hospital-340b-drug-profits-report/

Jane, S., and Emily, F. (2021). As big pharma and hospitals battle over drug discounts, patients miss out on millions of benefits. *KHN*. https://khn.org/news/article/340b-big-pharma-hospitals-battle-over-drug-discounts-patients-miss-out-on-millions-in-benefits/

Pifer, R. (2022). Hospitals, PBMs say drugmaker restrictions on 340B discounts stifling finances. *Healthcare Dive*. https://www.healthcaredive.com/news/hospitals-pbms-drugmaker-restrictions-340b-discounts/623277/

Pifer, R. (2022). Safety net hospitals report growing financial hit from loss of 340B drug discounts. Healthcare Dive. https://www.healthcaredive.com/news/safety-net-hospitals-financial-hit-340b-drug-discount-pharma/617844/

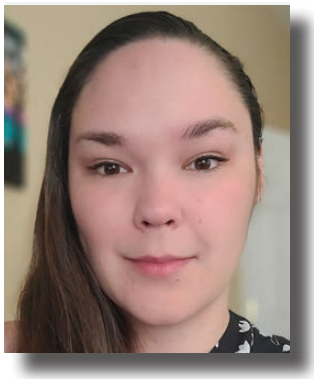
340B Health. Drugmakers cutting 340B discounts reported record revenues last year. *340B Health Informed*. https://340binformed.org/2022/03/drugmakers-cutting-340b-discounts-reported-record-revenues-last-year/

About the author

Fatimah Muhammad, MPH, is the Program Manager of 340B Department of Pharmaceutical Services at Saint Peter's University Hospital. She can be reached at fmuhammad@saintpetersuh.com.

The Value of Focusing on the Social Determinants of Health

Linda Schwimmer



Katie Bisaha

by Linda Schwimmer and Katie Bisaha

Now in its 25th year, the New Jersey Health Care Quality Institute (Quality Institute) works with organizations throughout the Garden State to improve the safety, quality, and affordability of health care for everyone. While much of our work focuses on health care price and safety transparency or quality improvement, we also work with community leaders and health systems to focus on what are referred to as the Social Determinants of Health (SDOH).

SDOH are the conditions under which people live, work, and play which can have a significant effect on their health. SDOH include job opportunities, housing, having clean air, water and open space, quality public education, and access to healthy foods. Differences in SDOH across racial, ethnic, and economic groups have created inequities in health outcomes, especially for historically marginalized groups. While we must work to improve the health care system, it is just as essential to focus on SDOH to achieve health equity within our communities. The private sector, working with government and nonprofit organizations, can play an important role in this effort.

Mayors Wellness Campaign – A Longstanding Partnership with Communities

Since 2006, the Quality Institute, in partnership with the New Jersey State League of Municipalities, has run the Mayors Wellness Campaign (MWC) – a community health initiative that provides evidence-based tools and strategies to mayors to address the SDOH within their communities. Through the MWC, we ask mayors to take an annual pledge to improve the health and wellness of their community. We then provide them and their wellness committees with tools, resources, and technical support to identify their community needs and take action. We perform this work with the support of health systems and providers in New Jersey, foundation funding, community partners including mental health providers, yoga or fitness instructors, teachers and school nurses, and many volunteers.

Throughout the COVID-19 public health emergency, the Quality Institute asked mayors and their local MWC leads to identify their highest priority needs. They pointed to increasing social isolation and mental health concerns, and access to healthy food. In response, the Quality Institute created tools, including a Social Isolation Toolkit, which offers a step-by-step guide to identifying and matching volunteers with older adults in the community to reduce social isolation, and a Mental Health Toolkit, which includes an overview of mental health and common mental health problems, strategies and program ideas that communities can implement to address mental health, and resources to share with residents who need mental health services and support. The Quality Institute also is working with several communities to implement and evaluate their program outcomes.

MWC's Other Current SDOH Initiatives – Food Insecurity and Land Use Planning

To address access to healthy foods, as well as other SDOH issues, on July 20, we hosted an open webinar and released two of our new *MWC Social Determinants of Health Tools*. We created the SDOH tools in collaboration with John Pepen, MPP, MD, a surgeon at Atlantic Health System's Overlook Medical Center and a Senior Fellow of the Quality Institute. The first tool we shared focuses on food security and how mayors can support their residents' access to nutritious foods. Already a top priority for MWC communities, in 2019, food insecurity affected 800,000 residents in New Jersey or 9% of households. Researchers estimate this number has nearly doubled because of the pandemic and resultant economic conditions. The new tool gives mayors and community leaders an overview of food insecurity, its impact on community

health, federal and state program enrollment, resources to help their residents, and evidence-based strategies to include in their MWC programs. The tool includes examples of successful community efforts. For example, the Montclair MWC is a part of the Montclair Community Farm Coalition, which includes several community partners dedicated to tackling local food insecurity. Their Mobile Food Stands reach residents where they are, focusing particularly on those in senior housing and others in need of food access by subsidizing produce prices and accepting the Supplemental Nutrition Assistance Program (SNAP). The Mobile Food Stand, which has 7 sites in Montclair and surrounding towns, served over 470 individuals, grew over 4,000 pounds of organic produce, and increased SNAP transactions while also engaging over 1,000 volunteers.

The second SDOH tool we released and discussed on the July 20 webinar addresses land use planning, which includes considering recreation, clean air and water, and safety – all issues that impact our health. This tool provides an overview of land use planning and community health, resources for incorporating health considerations into land use planning, and evidence-based land use strategies. An example we highlight is Paterson's MWC, which launched several efforts, including a Green Schoolyards Coalition, research on crime prevention through environmental design, and evaluation of its parks and recreation options. Most recently, Paterson partnered with St. Joseph's Health to secure a development grant to build the city's first Fitness Zone in Pennington Park featuring state-of-the-art fitness equipment and a playground. The zone was completed in February 2022 and is now fully operational.

The Paterson example can and should be emulated elsewhere. It will take significant and sustained public focus and investment to address SDOH through steps such as providing rental assistance, increasing the minimum wage, expanding social service programs, and providing good public education. In addition to public investment, the private sector, including health systems, will need to continue to address SDOH in the communities they serve. For example, Virtua Health recently launched another of its food access initiatives, the Eat Well Mobile Grocery Store, a refurbished NJ Transit bus that brings fresh foods at discounted prices to those who live in communities lacking access to fresh and nutritious foods. Initiatives like this enable health care providers to better support their patients to manage or avoid certain chronic diseases. Other health systems and insurers such as Horizon Blue Cross Blue Shield NJ are using technology tools that connect into their electronic medical records to screen patients for social needs and then directly refer them to services such as rental assistance agencies, food banks, transportation assistance companies and behavioral health services. Horizon's program, called "Horizon Neighbors in Health", connects Horizon members identified as being higher risk for social needs to a community health worker and personal health assistant to help the member access resources.

One way for everyone who wants to address SDOH is by connecting with local Mayors Wellness Campaigns, Public Health Departments, and other community based groups. Community partners can provide resources, expertise, access to services, and guidance to improve community health and address priority areas of SDOH. Organizations interested in connecting with their local MWC leadership can reach out Katie Bisaha, Community Health and Policy Associate, at kbisaha@njhcqi.org or visit the MWC website at www.njhcqi.org/mayors-wellness-campaign.

About the authors

As President and CEO of the New Jersey Health Care Quality Institute, Linda Schwimmer drives policies that advance health care safety, access and affordability. Linda sits on the board of the Leapfrog Group, a national patient safety advocacy group. Linda also served on the board and various committees of the National Quality Forum (NQF). She also served as a co-chair for Governor Phil Murphy's transition team on health.

Before joining the Quality Institute, Linda worked in various sectors including Director of Strategic Relations & External Affairs at Horizon Blue Cross Blue Shield of New Jersey; Director of Legislation and Policy for the New Jersey Department of Banking and Insurance and counsel positions with the New Jersey Senate Majority Office.

For over a decade, she was a bankruptcy and commercial lawyer in private practice.

Linda received a B.A. with honors from the University of California, Berkeley, and a J.D. from Georgetown University Law Center.

As a Community Health and Policy Associate, Katie Bisaha advances the Quality Institute's statewide community health initiatives, including Conversation of Your Life (COYL) and the Mayor's Wellness Campaign (MWC). Katie works closely with MWC leadership, local governments, community leaders and residents to improve overall health and wellness in New Jersey towns and cities.

Katie brings a range of public health experience and education to her work at the Quality Institute. Her experience includes work in substance use disorder prevention as well as in nutrition and wellness, including addressing obesity and food insecurity. She earned a Bachelor of Science degree in Nutrition and Food Science from Montclair State University.

•Focus on Finance•

Healthcare Leasing Arrangements

Tom Reck

By Tom Reck

Q. What does a healthcare company need to consider for leasing arrangements?

A. Leasing arrangements have become more and more commonplace in recent years. They are beneficial to those who are not utilizing their space to its fullest capacity and those needing additional space – often on a less than full-time basis. As such, the arrangements provide an additional source of revenue to the lessor and extra space (and potentially equipment) to the lessee.

Q. What should I know about Stark Law and Anti-Kickback Statutes?

A. Complicating these arrangements are concerns pertaining to the Stark Law (Stark) and Anti-Kickback Statutes (AKS). Violating either Stark or AKS, even unintentionally, can be problematic. As a result, it is beneficial to have a Fair Market Value (FMV) analysis prepared in order to guard against problems at a later date. Stark also relies upon the concept of General Market Value (GMV) in developing FMV. In the context of equipment or office space rental, GMV is defined as "the price that rental property would bring at the time the parties enter into the rental arrangement as the result of bona fide bargaining between a well-informed lessor and lessee that are not otherwise in a position to generate business for each other."

In addition to Stark, there is the concept of commercial reasonableness, which states, "the arrangement must further a legitimate business purpose of the parties to the arrangement and is sensible, considering the characteristics of the parties, including their size, type, scope and specialty." So, it is beneficial to be cognizant of the requirements in place as defined by FMV, GMV and commercial reasonableness.

Leasing arrangements can vary greatly. Simplistically, they may include office space solely, whereas, at the other end of the spectrum, they may consist of any number of things such as equipment, supplies, and other goods or services. In short, there are endless possibilities for leasing arrangements.

Pursuant to the most recent Stark Law (Section 411.357), the rental of office space and equipment may meet the exception to the referral prohibition – meaning the arrangement would not constitute a financial relationship if the following requirements were met:

1. The lease arrangement is set forth in writing that specifies the premises covered.
2. The duration of the arrangement is at least one year.
3. The space rented or leased is reasonable and necessary for the intended business purpose and is intended to be used exclusively by the lessee. An exception is common areas, which are dealt with separately. Similarly, equipment charges must be reasonable and necessary and used exclusively by the lessee.
4. The rental charges are set in advance and are consistent with Fair Market Value.
5. The rental charges are not based on:
   - A percentage of revenue raised, earned, billed, collected or otherwise attributable to the services performed or business generated within the office space.
   - Per-unit of service rental charges, to the extent that such charges reflect services provided to patients referred by the lessor to the lessee.
6. The lease arrangement is commercially reasonable even if no referrals were made between the lessor and the lessee.

As noted in item #4 above, the determination of FMV is a key component of meeting any exception to the referral prohibition. It is important to engage someone to consider the various components of the lease agreement, such as appraisals of real estate and/or equipment, square footage to be used, the expenses related to the property and/or equipment used, and an allowance for a profit. It is also beneficial to engage legal counsel to ensure that documents are properly drafted and that any additional considerations, such as changes in insurance coverage, are also addressed.

About the Author

Tom Reck, CPA/ABV, CFF, is a Partner with Withum and can be reached at treck@withum.com.

•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		

Has The Pandemic Become Endemic?

John Dalton

by John J. Dalton, FHFMA

The short answer – not quite yet!

The word "endemic" comes from the Greek *endēmos*, which means "in population." An endemic virus is relatively constant in a population with largely predictable patterns, with the seasonal flu perhaps the best example. It's likely that Covid-19 ultimately will achieve endemic status – it ain't going away.

To start with, it's helpful to understand what the differing terms mean, and epidemiologists and public health experts differentiate among outbreak, epidemic, pandemic and endemic as follows:

- An outbreak typically occurs in a specific location usually over a short period of time. An outbreak of Salmonella is a good example.
- Epidemics occur over a broader region, like the 2014-16 spread of the Ebola virus within three West African countries and Zika in 2014.
- A pandemic is an epidemic that spreads across many countries and continents globally like the "Spanish Flu" pandemic in 1918-19. Other examples include HIV/AIDS in the 1980s, SARS-CoV-1 (2002-04) and swine flu in 2009.
- A virus becomes endemic when it has predictable patterns and is relatively constant in the population. The rhinovirus that triggers the common cold and the seasonal flu are good examples.

Each virus has defining characteristics ranging from speed of replication to lethality and drug resistance. That's been clear as SARS-CoV-2's Alpha, Delta, Omicron and Omicron variants and sub-variants have each become more transmissible but cause differing symptoms and varying degrees of vaccine and drug resistance.

John M. Barry, author of *"The Great Influenza: The Story of the Deadliest Pandemic in History,"* offers a word of caution to those seeking to abandon precautions. While most histories of the 1918 pandemic say it ended in the summer of 1919 when a third wave of the respiratory contagion finally subsided, a variant that emerged in 1920 was lethal enough that it should have counted as a fourth wave. It occurred even though the U.S. population had plenty of natural immunity from the influenza virus after two years of several waves of infection. In 1921, the virus mutated into ordinary seasonal influenza.

Most public health experts currently agree that Covid is here to stay. Within the U.S., the Northeast is most likely to attain endemic status first, achieving herd immunity through vaccination or infection. The long and winding road to endemic status is likely to throw some more twists and turns our way before America can be fully comfortable coexisting with Covid.

So, when will Covid reach endemic status? The scientific consensus seems to be that it will occur when enough Americans gain immune protection from vaccination and/or from having been infected that there will be less transmission and much less Covid-related hospitalization and death, even as the virus continues to circulate. Over time and with sustained public health efforts ranging from mask wearing to vaccination and waste , the Covid pandemic could gradually become endemic.

About the author

John J. Dalton, FHFMA, is Senior Advisor Emeritus at BESLER, cofounder of the Healing American Healthcare Coalition and Editor of its newsletter, the ***Three Minute Read™****. He is coauthor of the recently published "Healing American Healthcare – Lessons from the Pandemic." John received HFMA's 2001 Morgan Award for lifetime achievement in healthcare financial management and was named 2017 Hospital Trustee of the Year by NJHA. Feel free to contact him with your thoughts and comments at jjdalton1@verizon.net.*

New Members

Vito Mazza
KINUM, Inc.
Cash Flow Faster Consultant
vito.mazza@kinum.com

Christopher Donegan
Richmond University Medical Center
Accounting Manager
christopherjdonegan@gmail.com

Joseph Leonard
Penn Medicine
Director, Ambulatory Practice Operations
joseph.leonard1@pennmedicine.upenn.edu

Cynthia Cooper
Trinity Health Systems
Helthcare Access Rep
ccooper@stfrancismedical.org

Rafid Kabir, CRCR
VCU Health System
Student
kabirr3@vcu.edu

Joseph Bisordi
Nuvance Health
Chief Population Health Officer
joseph.bisordi@nuvancehealth.org

Elli Kim, CSBI
Capital Health
Senior Financial Analyst
eskim220@gmail.com

Gayatri Ruapapara
HGS HealthCare
Manager Client Services
gayatri.rupapara@hgshealthcare.com

Chris Adie
Aston Carter
Director of Business Development
cadie@astoncarter.com

Ping Yu
KPMG LLP
Managing Director
pyu@kpmg.com

Charles Muldoon
KPMG
Director
ckmuldoon@kpmg.com

Mustafa Rahman
University Hospital
Administrative Fellow
wrachi39@hotmail.com

Michael Tavani
Virtua Health
Financial Analyst Coordinator
mtavani@virtua.org

Matilda Tili
NYC Health + Hospitals
Director of Billing
matildatili@gmail.com

Karla Cornejo
St. Francis Medical Center- Trenton, NJ
Patient Access RE
kcornejo20@hotmail.com

Steven Landgraber
Bronxcare Health System
Board Member
sjlcpa@msn.com

Bianela Ramirez
Trinity Health
Patient Access
bianelaramirez23@gmail.com

Kumar Aditya
Atlantic Health System
IT Director
kumar.aditya@atlantichealth.org

Danielle Decker
Capital Health
Decision Support Analyst
danni22789@yahoo.com

DonnaMarie Rivera
St. Francis Medical Center
HealthCare Access Rep
donna.rivera@stfrancismedical.org

Margaret Gove, CRCR
St. Francis Medical Center- Trenton, NJ
Patient Access Training
pgove@stfrancismedical.org

Donna Bowen
Virtua Health
Finance Manager Virtua Medical Group
dbowen@virtua.org

Yesenia Chicas-Gonzalez
St Francis Medical Center
601 Hamilton Ave Trenton NJ 08629
ER Registrar
ychicas-gonzalez@stmaryhealthcare.org

Amabel Montanez
St Francis Medical Center
601 Hamilton Ave Trenton NJ 08629
Patient Access
amabel.montanez@stfrancismedical.org

Marcelo Rivero
Trinity Health – St. Peters Health Partners
Billing & Follow-Up Representative
Trainee PBS-K
marcelo.rivero@trinity-health.org

Chastidy Santiago
St Francis Medical Center
601 Hamilton Ave Trenton NJ 08629
Benefits Advocate
chastidy.santiago@stfrancismedical.org

Cheryl Vancho
St. Francis Medical Center- Trenton, NJ
Revenue Integrity Rep
vanchoc@stfrancismedical.org

Blanca Mankiewicz
TD Bank
VP, Sr Treasury Management Officer
blanca.mankiewicz@td.com

Elizabeth Finnerty
Atlanticare Patient Access Team Lead
elizabeth.finnerty@atlanticare.org

Tenica Johnson-Lopez
St Josephs Regional Medical Center
Compliance Coding Auditor
johnsont@sjhmc.org

Matthew Kancy
Atlanticare Clinical Data Analyst
matthew.kancy@atlanticare.org

Linda Barrientos
Deborah Heart & Lung Center
Director of Finance
barrientosl@deborah.org

Eric Brenner
Deborah Heart & Lung Center
Financial & Decision Support Analyst
brennere@deborah.org

Edwin C. Cruz
Orlando Health
Accounts Receivable
edwin.cruz@orlandohealth.com

Silvana Capps
Thomas Jefferson University Hospital
Manager Business Analysis
silvana.capps@jefferson.edu

Ursula Rinaldi
Thomas Jefferson University Hospital
Business Analyst
ursula.rinaldi@jefferson.edu

Ashok Vegesna
Thomas Jefferson University
Postdoc Fellow
ashokvegesna21@gmail.com

Andre Maksimow
Bon Secours Mercy Health
Chief Diversified Growth Officer
amaksimow@bsmhealth.org

Natalie Edwards-Bell
CarePoint Health
Manager
nb260115@gmail.com

Muhammad Irfan Khan
Atlanticare
Patient Access Team Lead
muhammad.khan@atlanticare.org

Marayah Arolfo, CRCR
Atlas Rehabilitation and Healthcare
Business Office Manager
maray.arolfo@gmail.com

Abigail Parker, CSPR
The Buonopane Group, LLC
Analyst
16para01@gmail.com

Robert Mynar
Cerner Corporation
Academy Consultant
robert.mynar@cerner.com

Nicole Tuesday-Wright
Revu Healthcare
Senior Clinical Consultant
venntuesday@revuhealthcare.com

George Smith
Payscout LLC
Sales & Marketing Manager
operations@payscout.com

Sheila Archibald
Thomas Jefferson University Hospital
Manager
sheila.archibald@jefferson.edu

Jeannine Consalvo
Thomas Jefferson University Hospital
Manager
jeannine.consalvo@jefferson.edu

Wendy Grzadzielewski
Thomas Jefferson University Hospital
Sr. Director
wendy.grzadzielewki@jefferson.edu

Doris Rodriguez
St Francis Medical Center Trenton Nj
Registration
doris.rodriguez@stfrancismedical.org

Zachary Taylor
Thomas Jefferson University Hospital
Accounting Manager
zachary.taylor@jefferson.edu

The Power of Mentorship in Healthcare Leadership: A Student & Mentor Perspective

Fatimah Muhammad

Sabrina Lew

by Fatimah Muhammad, MPH and Sabrina Lew, BA/BS

Sabrina's Perspective

I am a student entering the workforce, and the whole experience is daunting. From the beginning, my initial thoughts are doubts and anxieties about whether my qualifications would meet the expectations of the company. It is a "make it or break it" situation for many starting their careers in terms of what they achieve or won't, and the first job can be the determining factor that influences the course of future professional endeavors.

Universities do their best to prepare students for the "real" world but ultimately, it comes down to the individual's grit that will shape their ambitions in the desired field. Nelson Mandala once said, "Education is the great engine of personal development." Whether or not a person is still in school or just graduating, learning is always going to be a constant in one's life. The world is always evolving and to stay the course, leaving no room for improvement, limits one's capacity to move forward as a contributing member of society.

As an intern in the 340B Pharmaceutical Services Department at Saint Peter's University Hospital I have had the honor to be part of the team working on important projects that have a direct impact on the hospital. When I had the opportunity to meet with the CFO to talk about the and present projects in front of upper-level management (while I worried I was underqualified to be in that position) the confidence that my team had in me was a motivation to excel. These types of hands-on experiences have been used as an educational tool, as a way of obtaining constructive criticism, and something that all students should have the opportunity for at the start of their professional careers.

From a new member's perspective, HFMA has provided unique opportunities to keep those in the field informed on current events and has rec-ommended ways on how or-ganizations can enhance their standards in order to benefit their staff. Expert opinions are brought to share their thoughts and members are recognized for their dedication to the community. These are just a few instances of how HFMA is holding itself accountable, ensuring that advancements are being made so that member organizations are up to date with the current state of the world.

With that being said, how can HFMA exceed expectations as a organization? Providing the opportunity to contribute with this article is a prime example of what can be done. It is imperative for companies to give entry-level employees and interns a greater level of responsibility and to give them more opportunities to prepare for the future. It is vital for employees to understand how businesses operate, and administrative tasks are only the tip of the iceberg.

By letting them be a part of the work, getting fresh viewpoints on projects, and allowing them to apply what they know to assignments they will get a more in-depth understanding of the program, encouraging them to utilize their experience to its fullest potential. With these implementations, active learning can occur, allowing companies and their interns to grow together as a community and shape the new generation of healthcare leaders.

Fatimah's Perspective

As an HFMA board member and mentor for future healthcare leaders it is important to understand that embedding leadership development in the university structure does not guarantee college graduates' success and places little emphasis on student experiences or outcomes. College degrees can provide knowledge of a subject matter, but being a part of HFMA ensures that a student possesses leadership attributes so that they will have a competitive advantage in changing today's healthcare landscape.

Mentoring in HFMA offers students many benefits, including the ability to build relationships, work towards change, inspire others, strengthen critical thinking skills, become effective cross-cultural communicators, network with other students, and gain an understanding of how payers and providers operate across healthcare.

The HFMA is a powerful program for students because it teaches them the link between leadership style and skills that support a healthy ecosystem and promote optimal performance. I am gratified to be part of the journey of future healthcare leaders of tomorrow who will improve bottom-line financial performance and foster a positive culture with teams who believe in driving strategic execution.

About the Author

Fatimah Muhammad is the 340B Pharmaceutical Services Program Manager at Saint Peter's University MC. She can be reached at fmuhammad@saintpetersuh.com.

Sabrina Lew, BA/BS is an, MPH Candidate at the University of Pittsburgh & 340B Pharmaceutical Intern at Saint Peter's University MC. Sabrina can be reached at

Fun Fact about Sabrina Lew: I have a collection of thrifted vintage cameras

Fun Fact about Fatimah Muhammad: I enjoy playing tennis and writing poetry

Chapter Past President Jack Farmer (1924-2022)

By John J. Dalton, FHFMA

The June 5 Star-Ledger reported that Chapter Past President Jack Farmer passed away at the ripe old age of 97. Born in Newark and raised during the Great Depression, Jack served in the US Navy during World War II, then attended Rutgers on the GI Bill graduating with a degree in Finance. During a lengthy career, Jack served as CFO at East Orange General Hospital, St. Elizabeth's Hospital and Hackensack Hospital. He completed his professional career as a Vice-President at New York (now Empire) Blue Cross and Blue Shield.

I first met Jack in September 1974 when Haskins & Sells (now Deloitte) assigned me to manage the implementation of New Jersey's first hospital rate-setting system (SHARE) under the Health Care Facilities Planning Act of 1971. He was CFO at Hackensack Hospital. The contract award was months late and we had only four months to draft regulations, conduct hospital training sessions, design reporting forms, collect data, hire and train rate analysts, design and implement the system, and produce Blue Cross and Medicaid inpatient payment rates for New Jersey's 108 acute care hospitals by mid-January.

It was a different time – no smartphones, email or personal computers. We knew we needed help and recruited a panel of CFOs to advise the team on prevailing practices in hospital accounting to ease the transition from responsibility accounting to functional cost reporting so that costs could be compared across hospitals. Although the law was unpopular, Jack and some colleagues – Jim Carroll from Morristown memorial Hospital, Tom Dalton (no relation) from Overlook Hospital and Keith McLaughlin from Perth Amboy General Hospital - agreed to serve as advisors. Their willing advice proved invaluable in assuring that a system would be in place by January 1975.

Sr. Cathleen Maloney was Chief of the Rate Setting program. The first Sister of Charity to obtain a CPA, she had been Controller at St. Elizabeth's Hospital prior to joining the Department of Health. The first cadre of Rate Analysts included Gene Arnone, Mike Dively, Jim Hull, Joe Lario, Chuck Lydon, George Popko and Al Rabin. It was a fast and furious four months, but inpatient payment rates were developed and issued by mid-January 1975. None of the more than 100 acute-care hospitals were pleased with their initial rate determinations and availed themselves of the appeals mechanism, but at least cash flow was maintained.

However, that's not the most important memory of Jack Farmer. When Medicare was implemented in 1966, the first-ever Medicare inpatient claim was processed and paid by New Jersey (now Horizon) Blue Cross. It was for an inpatient stay at East Orange General Hospital where Jack was CFO at the time. The check was hand-delivered to Jack – it made the 5 o'clock news! I'm sure that there must be a record of it in the Star-Ledger archives, but I was not able to find it.

"Smiling Jack" Farmer, one of America's Greatest Generation – rest in peace.

•Focus on...New Jobs in New Jersey•

JOB BANK SUMMARY LISTING

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

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

Job Position and Organization

SENIOR HEALTHCARE COMPLIANCE OFFICER
Rutgers University

VICE PRESIDENT, FINANCE
Hunterdon Healthcare System

BUDGET REIMBURSEMENT COORDINATOR
CentraState Healthcare System

FINANCE OPERATIONS ANALYST
CentraState Healthcare System

BILLING SPECIALIST
Preferred Behavioral Health Group

SAVE the DATE

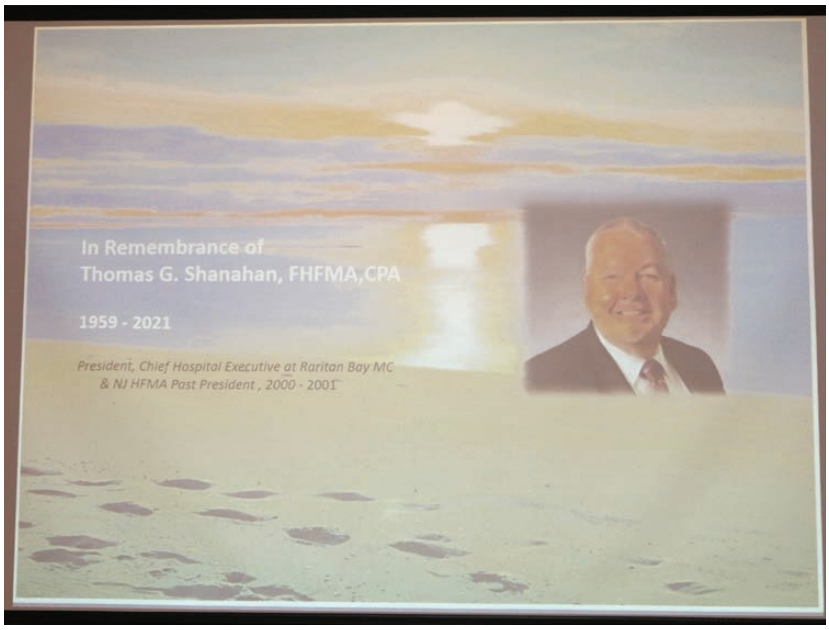
October 26-28, 2022
45th Annual Institute
The Borgata
Atlantic City

Watch for updates on all of these events, or visit the Chapter website at hfmanj.org

2022 NJ HFMA Golf Outing
Mercer Oaks
May 12, 2022


1B


MERCER OAKS
West
17
Par 4
405
385
365
300


In Remembrance of
Thomas G. Shanahan, FHFMA,CPA
1959 - 2021
President, Chief Hospital Executive at Raritan Bay MC
& NJ HFMA Past President , 2000 - 2001

NJ HFMA Leadership 2022-2023

Officers

Brian Herdman
NJ HFMA President
BHerdman@cbiz.com
CBIZ KA Consulting Services, LLC

Heather Stanisci
NJ HFMA President-Elect
hstanisci@annuityhealth.com
Annuity Health, LLC.

Maria S. Facciponti
NJ HFMA Treasurer
facciponti.maria@gmail.com
Elite Medical Receivables Solution

Jonathan Besler
NJ HFMA Secretary
JBesler@besler.com
BESLER

Hanna Hartnett
NJ HFMA Asst. Treasurer
Hanna.Hartnett@atlantcare
AtlantiCare Regional Medical Center

Advisory Council

Stacey Medeiros
stacey.medeiros@pennmedicine.upenn.edu
Penn Medicine Princeton Health

Michael McKeever
m.mckeever2@verizon.net
St. Peter's University Hospital

Erica Waller
erica.waller@pennmedicine.upenn.edu
Penn Medicine Princeton Health

Jill Squiers
jill.squiers@amerihealth.com
AmeriHealth New Jersey

Board of Directors

Scott Besler
Scott.Besler@Toyonassociates.com
Toyon Associates

Chris Czornyek
chris@hospitalalliance.org
Hospital Alliance

Alex Filipiak
Alexander.Filipiak@rwjbh.org
RWJBarnabas Health

Jason Friedman
JasonFriedman88@gmail.com
Hackensack Meridian Health

Jane Kaye
jane@hcfadvisors.com
Healthcare Finance Advisors

Board of Directors (Cont'd)

Dave Murray
DMurray@rumcsi.org
Richmond University Medical Center

Amina Razanica
arazanica@njha.com
New Jersey Hospital Association

Hayley Shulman
HShulman@Withum.com
WithumSmith+Brown, PC

Nicole Rosen
nrosen@acadia.pro
Acadia Professional

Associate Board Directors

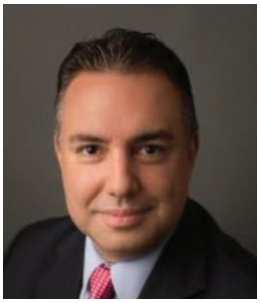
Kim Keenoy
Associate Board Director
Bank of America
Kim.Keenoy@bofa.com

Fatimah Muhammad
Associate Board Director
Saint Peter's University Hospital
fmuhammad@saintpetersuh.com

John Netunno
Associate Board Director
St. Joseph Regional Medical Center

Ex-Officio

Roger Sarao
RSarao@NJHA.com
New Jersey Hospital Association



Mike Costa
mcosta@ambulnz.com
DocGo

Committees

Fatimah Muhammad
Associate Board Director
Compliance, Audit, Risk & Ethics (CARE) Committee
fmuhammad@saintpetersuh.com

Ryan Peoples
Compliance, Audit, Risk & Ethics (CARE) Committee
RPeoples2@virtua.org

Jill Squiers
Communications Committee
jill.squiers@amerihealth.com
AmeriHealth New Jersey

Brian Herdman
Communications Committee
BHerdman@cbiz.com
CBIZ KA Consulting Services, LLC

Hayley Shulman
Education Committee
HShulman@Withum.com
WithumSmith+Brown, PC

Committees (Cont'd)

Sandra Gubbine
Education Committee
Sandra.Gubbine@atlanticare.org
AtlantiCare Health System

Lisa Weinstein
Education Committee
lisa.weinstein@bancroft.org
Bancroft

Kim Keenoy
Education Committee
Bank of America
Kim.Keenoy@bofa.com

Amina Razanica
Certification Committee
arazanica@njha.com
New Jersey Hospital Association

Alex Filipiak
Finance, Accounting, Capital & Tax (FACT) Committee
Alexander.Filipiak@rwjbh.org
RWJBarnabas Health

Hanna Hartnett
Finance, Accounting, Capital & Tax (FACT) Committee
Hanna.Hartnett@atlantcare.org
AtlantiCare Regional Medical Center

Dave Murray
Finance, Accounting, Capital & Tax (FACT) Committee
DMurray@rumcsi.org
Richmond University Medical Center

Maria S. Facciponti
Institute Committee
facciponti.maria@gmail.com
Elite Medical Receivables Solution

Brian Herdman
Institute Committee
BHerdman@cbiz.com
CBIZ KA Consulting Services, LLC

Nicole Rosen
Marketing/Networking
nrosen@acadia.pro
Acadia Professional

John Byrne
Marketing/Networking
JByrne56@gmail.com
The NYBB Group

Heather Stanisci
Marketing/Networking
hstanisci@arcadiarecovery.com
Arcadia Recovery Bureau

Daniel Demetrops
Patient Access Services Committee
ddemetrops@medixteam.com
Medix

Jacqueline Lily
Patient Access Services Committee
jacqueline.lilly@atlanticare.org
AtlantiCare Health System

Amina Razanica
Patient Access Services Committee
arazanica@njha.com
New Jersey Hospital Association

Committees (Cont'd)

Maro Coello
Patient Financial Services Committee
mcoello@afiliatedhmg.com

Steven Stadtmauer
Patient Financial Services Committee
sstadtmauer@csandw-llp.com
Celentano Stadtmauer & Walentowicz, LLP

Maria S. Facciponti
Patient Financial Services Committee
facciponti.maria@gmail.com
Elite Medical Receivables Solution

Tracy Davison-DiCanto
Payer & Provider Collaboration
Tracy.Davison-DiCanto@scasurgery.com
Surgical Care Affiliates

Lisa Maltese-Schaaf
Payer & Provider Collaboration
LMaltese-Schaaf@childrens-specialized.org
Children's Specialized Hospital

Michael McLafferty
Physician Practice Issues Forum
michael@mjmaes.com
MJM Advisory and Educational Services, LLC

Erica Waller
Physician Practice Issues Forum
erica.waller@pennmedicine.upenn.edu
Penn Medicine Princeton Health

James OConnell
Regulatory and Reimbursement
OConnellJ@ihn.org

Paul Croce
pcroce@greenbaulaw.com

Scott Besler
Regularoty and Reimbursement
Scott.Besler@Toyonassociates.com
Toyon Associates

Tiffani Bouchard
Revenue Integrity
tbouchard@panacainc.com
Panacea Healthcare Solutions

Nicole Tuesday-Wright
Revenue Integrity
venntuesday@revuhealthcare.com

Jonathan Besler
Revenue Integrity
JBesler@besler.com
BESLER

Lew Bivona
CPE Designation
lewcpa@gmail.com