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new jersey chapter
Spring 2021 • vol 67 • num 3

garden state focus

national excellence award winner

Business is beginning to bloom again in the Garden State

- John Dalton continues his series on the COVID-19 pandemic
- Federal "No Surprises Act" complements State laws
- Telehealth before and after COVID-19
- The New Jersey Economic Recovery Act of 2020 and its impact across the State

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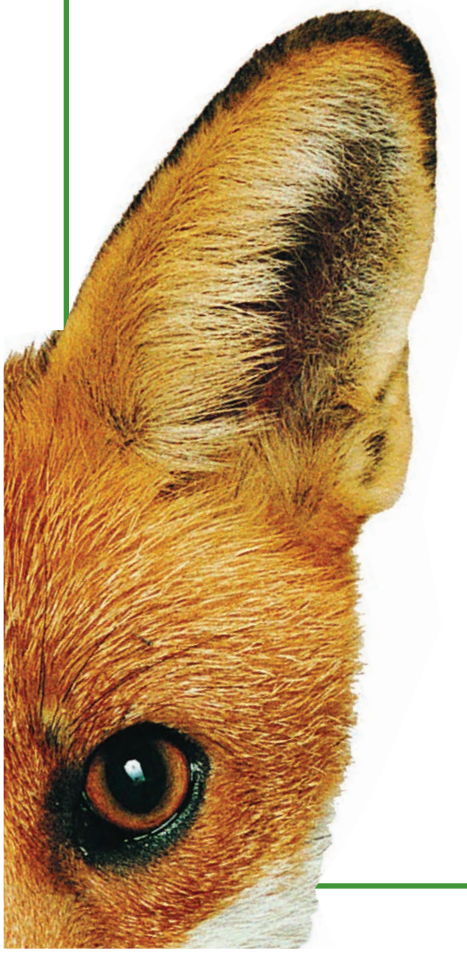

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Who's Who in the Chapter 2020-2021

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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:
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The President's View . . .

Stacey L. Medeiros

Goodbye winter, hello spring! Spring represents a period of rebirth and renewal as the weather warms and the flowers and trees bloom. The HFMA NJ chapter also goes through its own rebirth each spring when our chapter year renews on June 1. As challenging as the past year has been for all of us, the time has moved quickly and it's hard to believe this is my final letter as chapter President. On June 1 I will turn the reigns over to the very capable hands of our current President-Elect, Jill Squiers. Jill brings the experience and leadership qualities that will successfully guide our chapter as we transition into the next year. Congratulations Jill and best of luck in your tenure.

To close out this year, we are excited for our first and only live event of chapter year 2020-2021, our Golf Outing, May 6th at Mercer Oaks in West Windsor, NJ. We've been working closely with the venue to ensure proper safety protocols will be in place and are confident we will be able to host a safe and enjoyable event. In addition, both our sponsorship and registration fees have been discounted for this year in light of the financial challenges many are facing. If you will be joining us for golf, please note the new schedule for this year, starting in the afternoon:

- 11:30am – Registration and Lunch
- 1:00pm – Shotgun Start
- 5:30pm – Cocktail Hour, Dinner Buffet with Open Bar

Not a golfer? You can register just for the cocktail hour and dinner at a discounted price. Take advantage of the opportunity to see those you haven't seen in a long time in a safe, outdoor, socially distanced setting. Let's enjoy the spring weather and reconnect!

This may be the only live event for this chapter year, but I would be remiss not to mention the vast virtual offerings which we've done in place of live events. From June 2020 through March 2021 our chapter has offered over 30 virtual education events to our members, through a combination of chapter hosted programs, sponsor offerings and regional collaborations. This includes the first ever virtual Annual Institute, hosted over the course of 4 days in October. Throughout the year the chapter also hosted six networking events, leading the way with creative ideas including a wine tasting and a cooking lesson. And there is more to come in the last months of the chapter year. Check your email and the chapter website for information on upcoming webinars and networking events.

Being my last letter, I'd like to close by thanking those who have provided so much time, assistance and dedication to the chapter this year, in particular:

- Scott Besler, Brian Herdman and the entire FOCUS committee for continuing to produce our award winning magazine throughout the pandemic. For the first time, our magazine was published in an electronic format this year, providing valuable information for those who could not receive the print edition in office.
- All of the committee chairs, co-chairs and volunteers who stepped up to pivot our usual in person education sessions to virtual sessions.
- Our fantastic Membership & Networking committee, headed by Nicole Rosen and John Byrne, for their work on the aforementioned networking events and keeping our members engaged.
- The entire HFMA NJ board for their support, suggestions and guidance throughout the year.
- Our sponsors who have continued to support us, despite facing financial hardships.

It's been my pleasure to serve as your President and I look forward to seeing what the chapter will accomplish in the future.

Respectfully,
Stacey L. Medeiros

From The Editor . . .

Scott Besler

On behalf of the *FOCUS* and Communications committee, I hope this edition finds you well on your way to enjoying your spring. As many of us that have called New Jersey home for many of our years, we know that spring has almost become forgotten season due to its brevity in recent years. We were prepared to wait for it, since "flattening of the curve" has taken what seems to be the longest two weeks ever. Now with vaccinations and a year to understand this pandemic we seem to be headed in the right direction.

The next few months will continue to bring challenges to our industry. Many of our hospitals have had volumes decrease and not rebound as quickly or arrive at levels that are necessary to make a healthy margin. Transparency will continue to be the goal of not only the past administration but the current one. Providers and payers have a responsibility to educate their "customers" and ensure that the mission can be attained.

COVID-19 has had a tremendous impact on our industry. The next several months will result in the recoupment of the advanced payments, as well as audits of CARES Act funding many hospitals received. Hospitals need to work with their legislators and hospital associations to ensure that these conducted as a uniform and sustainable approach.

We hope to see you, outside on May 6th, 2021 at Mercer Oaks Golf Course in West Windsor, for our annual golf outing. Many of us will be in the woods and not congested on the fairway so social distancing should be upheld.

As they say, spring thyme is always the best!!

Thank you and enjoy!!!

Please stay well during this challenging time!

We thought you might need a couple more bottles.

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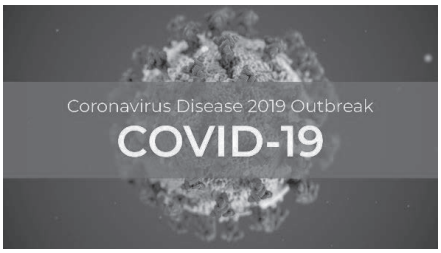
The COVID-19 Pandemic – How is the U.S. doing? Part 4

John Dalton

by John Dalton, FHFMA



The short answer – the roller coaster ride continues with vaccines vs. virus variants in the race to recovery. The key issue facing the U.S. is whether a Spring Break/Passover/Easter surge can be avoided, unlike the Thanksgiving/Hanukah/Christmas surge that led to more than 95,000 deaths in January. More on that later, but first, some brief background.

On December 31, 2019, the government in Wuhan, China, confirmed that health authorities were treating dozens of cases of a pneumonia of unknown origin. Three weeks later, the United States confirmed its first case in Washington state – a man in his 30s developed symptoms after returning from Wuhan. The World Health Organization (WHO) declared a global health emergency on January 30 and subsequently named the disease Covid-19, an acronym for coronavirus disease 2019. On March 11, the WHO declared Covid-19 a global pandemic.

Meanwhile, during February, more than 2.2 million travelers arrived in New York from Europe, some already infected by the novel coronavirus. New Jersey's first case was confirmed March 5. Shortly thereafter, the New York Metro Area joined Milan and Madrid as the global epicenters of the worst pandemic in over a century, and the author began tracking and reporting on the performance of the 37 member nations of the Organisation for Economic Co-operation and Development (OECD) in dealing with the pandemic. The key metric tracked is fatality rate per 100,000 residents.

The first three parts of this series were written May 1, September 21 and November 30, 2020, respectively. This 4th (and hopefully final) article is written as of March 31, 2021, a full year after the WHO's global pandemic declaration. Over the course of the past year, Australia, Japan, New Zealand and South Korea have consistently led the OECD in protecting their residents from Covid-19. On the other hand, Belgium, Italy, the U.K. and the U.S. have consistently ranked in the bottom quartile of the OECD with the highest fatality rates in the developed world.

Biden Declares War on Pandemic

Inaugurated the day after America's death toll surpassed 400,000, President Joe Biden wasted no time attacking the pandemic.[1] That afternoon, his first three Executive Orders targeted Covid-19: requiring masks on federal property, rejoining the World Health Organization and establishing a White House Covid-19 response team led by Jeff Zients. Biden's executive actions were also intended to set an example for state and local officials as they try to rein in the virus and drew praise from U.S. Chamber of Commerce President Suzanne Clark calling it "*a smart and practical approach.*"

The series of Executive orders and presidential directives issued during President Biden's first full day in office signaled a more centralized federal response to the spread of Covid-19, including:[2]

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

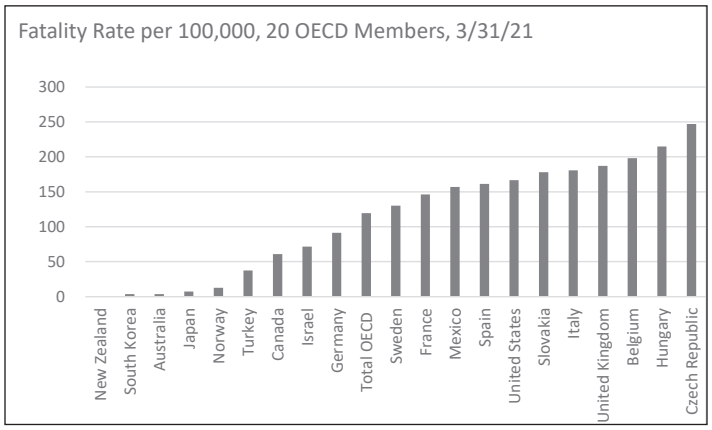
Agencies also were directed to identify areas where the administration could invoke the Defense Production Act to increase manufacturing, such as PPE, swabs, reagents, pipettes and syringes. The orders Biden signed were aimed at jump starting his national Covid-19 strategy to increase vaccinations and testing, lay the groundwork for reopening schools and businesses, and immediately increase the use of masks. Promising stringent adherence to public health guidance, Biden declared: *"To a nation waiting for action, let me be clear on this point: help is on the way."*[3]

Is the strategy working? Let's look at where America stands at day 70 of the Biden Administration.

#30 of 37 in the OECD

With 551,747 Covid-19 deaths as of March 31, the U.S. fatality rate of 166.7/100,000 ranked 30th of the 37 OECD member nations, just below Portugal in the bottom quartile (see Table 1: Confirmed Cases and Fatality Rates, OECD Countries as of 3/31/2021). The U.S. is trailed by Slovakia, Italy, the U.K., Slovenia, Belgium, Hungary and the Czech Republic. Part 3 of this series highlighted the alarming increase in fatality rates in Central Europe that began in the Fall.

Chart 1.



Covid-19 has continued to rage, and Hungary and the Czech Republic have displaced Belgium with the highest fatality rates among OECD member nations (see Chart 1: "Fatality Rate per 100,000, 20 OECD Members, 3/31/21"). Nonetheless, Hungary's Prime Minister Viktor Orban has said that his government will not tighten restrictions and is determined to continue moving to reopen society.[4] After a month of lockdown measures to combat the virus, Mr. Orban said, the plan to reopen stores after Easter, followed by schools and then restaurants and hotels, would not change.

Conversely, New Zealand, Australia, South Korea, Japan and four of the Scandanavian countries (Norway, Finland, Iceland and Denmark) continue to rank in the first quartile, just ahead of Canada at #10. Sweden remains the outlier among the Scandanavian countries at #23 with a fatality rate of 129.8/100,000. Sweden's flawed attempt at herd immunity had it at #33 of 37 as late as July 30, 2020.

Last week, on a CNN documentary titled "COVID WAR: The Pandemic Doctors Speak Out,"[5] Dr. Deborah Birx, a member of Trump's White House coronavirus response team, said that although the first 100,000 deaths were unavoidable, *"the rest of them, in my mind, could have been mitigated or decreased substantially."* Birx added: *"The majority of the people in the White House did not take this seriously."* Brett Giroir, the nation's coronavirus testing chief under Trump, admitted, *"When we said there were millions of tests available, there weren't.… There were components of the test available, but not the full… deal."* Former director of the CDC Robert Redfield said that

Table 1. Confirmed Cases and Fatality Rates, OECD Countries as of 3/31/2021

Rank	Confirmed Cases (1)	Fatalities (1)	Fatality Rate (%)	37 OECD Countries	Population (2)	Cases per 100,000	Fatalities per 100,000
1	2,497	26	1.0%	New Zealand	4,822,233	51.8	0.54
2	103,088	1,731	1.7%	South Korea	51,269,185	201.1	3.38
3	29,304	909	3.1%	Australia	25,499,884	114.9	3.56
4	474,566	9,155	1.9%	Japan	126,476,461	375.2	7.24
5	6,205	29	0.5%	Iceland	341,243	1,818.4	8.50
6	95,695	673	0.7%	Norway	5,421,241	1,765.2	12.41
7	77,452	844	1.1%	Finland	5,540,720	1,397.9	15.23
8	3,317,182	31,537	1.0%	Turkey	84,339,067	3,933.1	37.39
9	231,295	2,420	1.0%	Denmark	5,792,202	3,993.2	41.78
10	984,963	22,936	2.3%	Canada	37,742,154	2,609.7	60.77
11	106,424	902	0.8%	Estonia	1,326,535	8,022.7	68.00
12	833,040	6,203	0.7%	Israel	8,655,535	9,624.4	71.67
13	263,689	8,093	3.1%	Greece	10,423,054	2,529.9	77.65
14	2,828,870	76,459	2.7%	Germany	83,783,942	3,376.4	91.26
15	235,854	4,587	1.9%	Ireland	4,937,786	4,776.5	92.90
16	1,292,218	16,686	1.3%	Netherlands	17,134,872	7,541.5	97.38
17	102,363	1,899	1.9%	Latvia	1,886,198	5,426.9	100.68
18	546,229	9,339	1.7%	Austria	9,006,398	6,064.9	103.69
19	61,642	746	1.2%	Luxembourg	625,978	9,847.3	119.17
20	601,124	10,334	1.7%	Switzerland	8,654,622	6,945.7	119.40
21	995,538	23,135	2.3%	Chile	19,116,201	5,207.8	121.02
22	2,397,731	63,255	2.6%	Colombia	50,882,891	4,712.3	124.31
23	804,886	13,465	1.7%	Sweden	10,377,781	7,755.9	129.75
24	216,119	3,574	1.7%	Lithuania	2,722,289	7,938.9	131.29
25	4,646,127	95,502	2.1%	France	65,273,511	7,117.9	146.31
26	2,321,717	56,045	2.4%	Poland	37,846,611	6,134.5	148.08
27	2,232,910	202,633	9.1%	Mexico	128,932,753	1,731.8	157.16
28	3,284,353	75,459	2.3%	Spain	46,754,778	7,024.6	161.39
29	821,722	16,848	2.1%	Portugal	10,196,709	8,058.7	165.23
30	**30,467,755**	**551,747**	**1.8%**	**United States**	**331,002,561**	**9,204.7**	**166.69**
31	361,185	9,719	2.7%	Slovak Republic	5,459,642	6,615.5	178.02
32	3,584,899	109,346	3.1%	Italy	60,461,826	5,929.2	180.85
33	4,359,921	126,955	2.9%	United Kingdom	67,886,011	6,422.4	187.01
34	215,602	4,047	1.9%	Slovenia	2,078,938	10,370.8	194.67
35	876,842	22,966	2.6%	Belgium	11,589,623	7,565.8	198.16
36	652,433	20,737	3.2%	Hungary	9,660,351	6,753.7	214.66
37	1,532,232	26,421	1.7%	Czech Republic	10,708,981	14,307.9	246.72
	71,965,672	1,627,362	2.3%	Total OECD	1,364,630,767	5,273.6	119.3

DATA SOURCES:

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

Health and Human Services Secretary Alex Azar personally tried to change scientific reports that the White House didn't like. Former HHS Secretary Azar denies Redfield's assertion.

Whatever the ultimate truth, it's clear that the Trump Administration's failure to take the pandemic seriously resulted in well over 100,000 avoidable American deaths:

- If the U.S. had merely matched the OECD's average fatality rate/100,000 of 119.3, 157,000 more Americans would be alive today.
- If the U.S. had matched Germany's performance, 250,000 more Americans would be alive today.
- If the U.S. had matched the Scandanavian countries, 339,000 more Americans would be alive today.
- If the U.S. had matched Canada, 350,000 more Americans would be alive today.

Turning to the data from the states, the fatality rates for the Northeastern states that were the global epicenter of the pandemic last March and April continue to rank among the highest in the developed world (see Chart 2: "Fatality Rate/100,000,

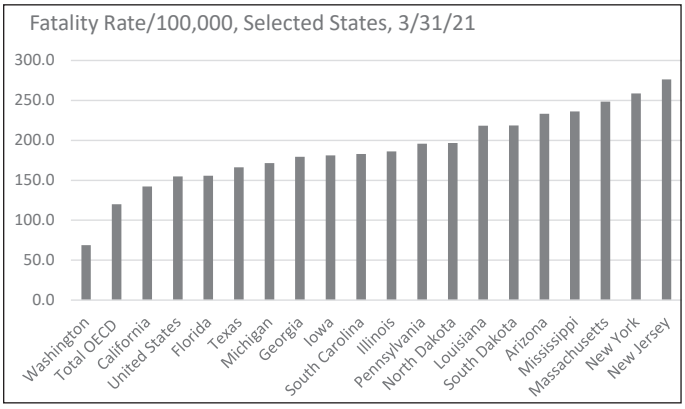
continued on page 8

continued from page 7

Selected States, 3/31/21"). To place the state data in perspective, the Czech Republic's fatality rate of 246.7/100,000 is the highest in the OECD, tied with Massachusetts, but lower than either New York or New Jersey.

As noted earlier, America's first confirmed case of Covid-19 occurred in Washington state, followed by an outbreak in a Kirkland nursing home. The state reacted immediately and has continued to protect its residents better than the OECD's average (see Table 2: Ten states change in fatality rates, 9 months ended 3/31/21). Washington's fatality rate of 68.7/100,000 would place it in at #12 in the OECD, between Estonia and Israel. Despite a winter surge in Southern California that had ICUs running out of capacity, the state's fatality rate of 142.2/100,000 remains below the U.S. average of 154.8/100,000 and equivalent to #25 in the OECD, between Lithuania and France.

Chart 2.



After being overwhelmed from mid-March through April 2020, New York and New Jersey's fatality rates have been below the U.S. average of 116.2/100,000 for the nine months ended March 31, 2020. Massachusetts and Pennsylvania have been less successful in controlling the pandemic, as have several of the Sunbelt states (e.g., Arizona, Georgia, Florida, South Carolina and Texas). And, as reported in Part 3, the annual Sturgis, South Dakota Motorcycle Rally from August 7-16 was a super spreader event on steroids, producing surges throughout the North Central Midwest and Mountain states.

Vaccine Rollout

On December 8, President-Elect Biden set a goal of administering 100 million vaccine doses in his first 100 days.[6] That goal was reached on day 58, and the U.S. now is on pace to administer more than 200 million doses in the first 100 days. On March 11, the one-year anniversary of the WHO's global pandemic declaration, President Biden urged all states, tribes and territories to make all American adults eligible for a Covid-19 vaccine by May 1.[7]

Table 2. Ten states change in fatality rates, 9 months ended 3/31/21

State	06/30/20	03/31/21	Difference	% Change
Washington	17.3	68.7	51.4	297.1%
OECD Average	**26.2**	**119.3**	**93.1**	**355.3%**
New York	161.5	258.6	97.1	60.1%
New Jersey	169.1	276.3	107.2	63.4%
Michigan	62.0	171.4	109.4	176.5%
United States	**38.6**	**154.8**	**116.2**	**301.0%**
California	15.2	142.2	127.0	835.5%
Massachusetts	117.3	248.5	131.2	111.8%
Florida	16.3	155.6	139.3	853.4%
Pennsylvania	51.9	195.9	144.0	277.5%
Georgia	26.4	179.4	153.0	579.5%
Texas	8.3	166.4	158.1	1904.8%

On February 27, the Food and Drug Administration issued an emergency use authorization (EUA) for Johnson & Johnson's adenovirus vaccine, further expanding the availability of safe effective vaccines for Covid-19.[8] The vaccine was 72% effective in the US, compared to 66% in Latin America and 57% in South Africa. Unlike the Pfizer/BioNTech and Moderna mRNA-based vaccines, J&J's Janssen vaccine requires only one injection and can be stored for at least three months at 36-46F. Novavax expects data from a 30,000-person trial in the United States and Mexico by early April. A late-stage trial in the UK found Novavax's vaccine 96% effective against Covid-19's original variant and 86% effective in protecting against the more contagious B.1.1.7 variant.[9]

With Americans being vaccinated at a rate of 3 million per day, more than 154 million doses have been administered. Nearly 100 million have received at least one shot and 56.1 million are fully vaccinated, 17.1% of the U.S. population.

The wild card in the equation is the emergence of virulent variants as the novel coronavirus continues to mutate. Of particular concern are the Brazilian, British and South African variants, all of which are more highly transmissible. However, all three vaccines with FDA approval have proven effective in preventing severe disease against the variants.

With ample vaccine supplies, the U.S. now is in a vaccine vs. virus variants race to recovery, providing that a Spring Break/Passover/Easter surge can be avoided, unlike the Thanksgiving/Hanukah/Christmas surge that led to 95,000 deaths in January.

The American Rescue Plan Act

The March 11 enactment of the $1.9 trillion American Rescue Plan Act (ARPA) contains the most extensive health insurance improvements for Americans since the Affordable Care Act (ACA) became law 11 years ago.[10] The law temporarily extends the eligibility criteria for ACA subsidies to include people with incomes above 400% of the federal poverty level so that no one must pay more than 8.5% of their income on insurance premiums. The Congressional Budget Office estimates

that the ACA changes will extend coverage to 2.5 million uninsured Americans. The federal government will cover 100% of COBRA premiums for laid-off workers between April 1 and September 30. The package also offers two years of additional federal funding to encourage Medicaid expansion in the 12 states that have not extended coverage to low-income adults.

The ARPA also contains important provisions to deal with the economic consequences of the pandemic, including $1,400 stimulus checks, expansion of the child tax credit, support for low- income families and child-care facilities, and rent support. Economists estimate that the poorest fifth of Americans will experience a more than 20 percent increase in their incomes. The ARPA should reduce poverty by one-third, reducing the number of people living below the federal poverty level from 44 million to 28 million. While these provisions are not directed at healthcare, they improve the social determinants of health, the conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes.

In a related development, President Biden extended a special enrollment period to allow people to sign up for health insurance through the federal health insurance marketplace through August 15.[11] The extended open enrollment period will allow Americans to take advantage of new savings under ARPA. However, the ARPA subsidy provisions are temporary, lasting for two years, retroactive to January 1, 2021.

A Return to Normal?

After a year of riding the Covid-19 roller coaster, Americans yearn for nothing less than a return to a normal lifestyle. In a recent article in the Atlantic, Joe Pinsker lays out a timeline for a likely return to a new normal.[12] He expects an uncertain spring, an amazing summer, a cautious fall and winter, and finally, relief.

Given that the wild card is the potential emergence of virulent vaccine-resistant variants, daily life will continue to be far from normal for the next few months. By late spring, small gatherings of vaccinated people should be feasible. At some point between June and September, the combination of widespread vaccinations and warmer weather may make many activities much safer, including taking public transit, being in a workplace, dining inside restaurants, and traveling domestically. However, experts don't foresee the return of indoor concerts, full stadiums or high levels of international travel yet.

The summer reprieve could be temporary. Some resurgence of the virus is likely in the fall as activities move indoors. If stubborn variants do circulate, new vaccines should be able to tame them relatively quickly. While there might be a need to revert to some of the precautions from earlier in the pandemic, the disruptions to daily life are likely to be short-lived. Beyond next winter, experts' predict a return to whatever qualifies as normal in the post-pandemic future. The virus will still exist, but like the flu it will circulate primarily in the colder months.

This author for one hopes that Mr. Pinsker is correct. Meanwhile, wash your hands, watch your distance and wear a mask.

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Measuring Uncompensated Care

by Fred Fisher

Fred Fisher

Thank you to hospital teams in New Jersey providing and supporting essential care during the extraordinary times of the COVID-19 public health emergency. As we focus on trends of uncompensated care, we also respect the current strain on providers and patients. Toyon looks to continue collaborating with healthcare leaders in New Jersey and across the country to recognize all current and lingering costs from COVID-19 – direct, indirect, and stranded.

This article measures the current status of uncompensated care, including recommendations on CMS's proposed Worksheet S-10 instructions, effective for Federal Fiscal Year (FFY) 2021 cost reporting.

The Affordable Care Act (ACA)

According to the ACA, Medicare's Uncompensated Care Disproportionate Share (DSH) recognizes "the amount of uncompensated care for…treating the **uninsured**."

"Uninsured" - as opposed to "charity" (or similar for low-income patients) – presents the following questions:

- When is a patient considered uninsured?
- What is the difference between low-income uninsured patients and all other patients?
- How does a comprehensive process identifying all categories of uninsured patients affect hospital operations and the financial assistance policy?

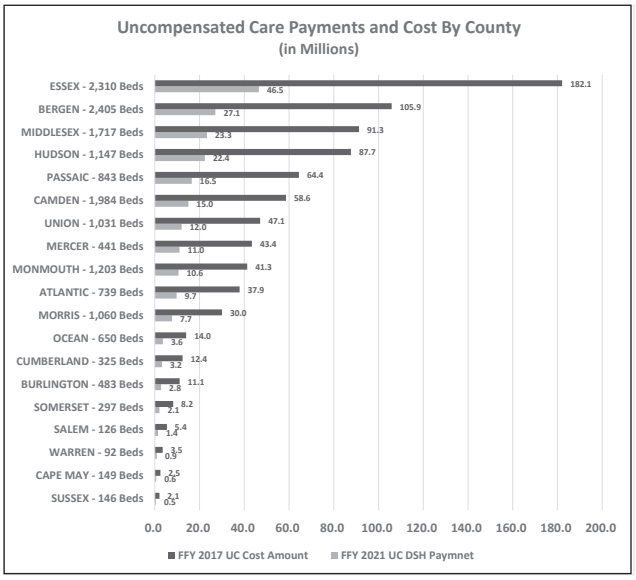
CMS's proposed cost report instructions to provide more insight to these questions, while we look to provide recommendations for hospital teams.

Uncompensated Care in New Jersey

For context, please see the illustration below breaking down $850 million of uncompensated care cost in FFY 2017 used as the basis for $217 million in UC DSH payments to New Jersey hospitals for FFY 2021.

Notable Proposed Cost Report Changes

In November 2020, CMS proposed new cost reporting instructions for FFY 2021 uncompensated care cost reporting on Worksheet S-10.[1] These proposed instructions include changes and clarifications in reporting noteworthy categories of uncompensated care cost:



- **Allowed:** Liability for patients with insurance but determined to be uninsured.

More under "Other Uninsured Charity Care"

- **Not Allowed:** Charge discounts from inferred contractual relationships.

More under "Inferred Contracts and Significant Losses"

- **Allowed:** Implicit Price Concessions[2] are reportable as bad debt costs.

More under "Bad Debt and Discovery"

- **Not Allowed:** Sub-acute care costs outside general short term hospital inpatient and outpatient services (not billable under the hospital CCN). This is a major shift in reimbursement.

More under "Short Term Hospital Services Only"

Other Uninsured Charity Care

CMS's proposed language clarifies providers may report other forms of "charity" related to insured patients, provided this care is in the financial assistance policy. Specifically, CMS states providers may report:

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- the "…portion of total charges for insured patients that were determined uninsured for the entire hospital stay;"[3] and
- "charges other than deductible, coinsurance and copay (C+D) amounts that represent the insured patient's liability for medically necessary hospital services"[4]

Both instructions relate to insured patients with charges that are not covered by the patient's insurance carrier. Therefore, providers may consider reporting **non-covered charges and exhausted benefit charges from all payers as forms of charity care**, provided these discounts are specified in a hospital's financial assistance policy.

But what does it mean to specify non-covered charges from all payers as charity care in a financial assistance policy? For tax exempt providers, how does allowing non-covered charges from all payers relate to IRS 501 (r) requiring hospitals to include amounts and methods for patients to receive free or discounted care?

Contrary to complex cost reporting instructions, the financial assistance policy is a public facing document designed to help patients navigate the healthcare system. As more cost reporting instructions are dependent on this policy, it becomes muddied with caveats, as opposed to a concise, easy-to-read, patient-centered document. An internal policy – apart from the patient financial assistance policy – delineating the accounting of charity care may be prudent to 1) maintain a separate patient friendly policy; and 2) present evidence of compliance with cost report instructions.

Providers are reimbursed approximately $250,000 for every $1M in charity cost.[6]

When it comes to financial assistance policy governance, generally CMS does not regulate how providers articulate charity care in their policies (one notable exception relates to Medicare FFS bad debts, whereby CMS does not allow presumptive charity eligibility determinations). For all other forms of charity, CMS states:

> "(CMS) does not set charity care criteria policy for hospitals, and **within reason**, hospitals can establish their own criteria for what constitutes charity care in their charity care and/or financial assistance policies."[5]

CMS has not further elaborated on what constitutes "within reason," to be considered as charity care. However, as presented above, the proposed cost report instructions indicate a broad definition including charges from a remaining patient liability.

Recommendation: Evaluate the reporting of non-covered and exhausted charges from all payers against current hospital procedure. Hospital teams are encouraged to assess:

- If patients are billed the outstanding amount.

  For instance, a provider may pursue payment from secondary and tertiary payers, and then the patient for non-covered services.
- When and where these transactions are reported in the patient financial system (i.e., account adjudication).

  For instance, after collection attempts, and a payment is not received, the resulting "write-off" can end up in various transaction types including 1) bad debt – recognized as uncompensated care cost; 2) contractual allowance – ***not*** recognized as uncompensated care cost; or 3) denial | non-covered transaction code – recognition of uncompensated care cost **depends** (typically, providers report charges related to non-covered Medicaid from these codes).
- and 3) the benefit of changing policy and procedures so these amounts may be recognized as charity care.

A statistic to help this evaluation: Providers are reimbursed approximately **$250,000 for every $1M in charity cost.[6]**

A thought on policy variation and Section 501(r) – For reporting as uncompensated care cost, it is important to include financial assistance policy language discussing non-covered charges as patient financial assistance. This helps ensure the policy includes the basis and method patients may receive financial assistance. In question is the appropriateness of two beneficiaries with the same plan, whereby one is responsible for the coinsurance, while the other received charity related to a non-covered service. This is an important question that must be considered and continuously evaluated.

Inferred Contracts and Significant Losses

As discussed above, non-covered charges and exhausted benefits charges from all payers are forms of charity care. Okay got it. However, CMS also proposes providers cannot report charges from insured patients under contract, or inferred contract with the hospital. In the proposed cost report instructions for FFY 2021, CMS states providers may report:

> "the portion of total charges for patients with coverage from an entity/insurer **that <u>does not</u> have a contractual or inferred contractual relationship** (a contractual relationship between an insurer and a provider will be inferred where a provider accepts an amount from an insurer as payment, or partial payment, on behalf of an insured patient) with the provider."

Separate from a "non-covered charge," this proposed language seemingly follows the principle that payment shortfalls are not a form of charity care, focusing on insured patients not under contract with the hospital (e.g., "out of network"). Consider the following example:

- Charges: $200,000
- Cost: $50,000
- Payment from Auto Policy: $5,000
- Unreimbursed Cost = $45,000

CMS's proposed instructions imply although a provider accepted a sizable charitable discount, the $45,000 shortfall may not be considered a form of charity care.

However, this brings back the question – **at what point does this patient become uninsured?**

Recommendation: Evaluate the out of network population, and determine if "splitting the account" is appropriate to break-apart the insurance portion from the patient portion. If the $45,000 is considered as the patient portion, this may be the practical approach for recognizing the amount as charity care.[7] As discussed above, this accounting exercise may be another reason an internal policy is beneficial to hospitals, while maintaining a separate patient centered document.

It does not go unnoticed developing an internal policy may become a "Pandora's box" identifying all types of charity care – resulting in variation of DSH hospitals across the country. To address this issue, it is recommended CMS and other industry leaders develop a payment to cost ratio for out of network reimbursement. Amounts below a threshold of "normal and customary" rates should be considered and re-evaluated as charity care eligible.

Bad Debt and Discovery

After years of industry contemplation, CMS's cost report instructions for reporting bad debt includes implied price concessions.[8] Essentially, this is **business as usual for reporting bad debts on Worksheet S-10 of the cost report**. Due to the change in bad debt reporting for audited financial statements, during audit providers may not be able to produce a bad debt "roll forward" schedule.[9] In these cases, it is recommended providers disclose how "bad debts" relate to financial statements and request to be waived from the requirement of producing this reconciliation.

Although it is business as usual for reporting bad debts, providers continue to discover anomalies with prior year bad debt accounts. More specifically, providers are discovering old bad debt accounts that qualify for charity care.

Why is this important? Because when patient C+D amounts are reported as bad debt, they are reduced to an amount less than cost. However, when patient C+D amounts are reported as charity care, the full amount is recognized as uncompensated care cost. CMS has employed this calculation since the inception of uncompensated care cost for Uncompensated Care DSH payments (starting FFY 2018).

Consider the impact to uncompensated care cost from thousands of accounts like the example below:

Reported as Bad Debt

- Amount Written Off to Bad Debt: $5,000
- Bad Debt Reduced to "Cost": $1,250 (amount of recognized uncompensated care cost on Worksheet S-10)

Reported as Charity Care

- Amount Written Off to Charity Care: $5,000
- Charity Cost: $5,000 (amount of recognized uncompensated care cost on Worksheet S-10)

The question that looms for providers discovering charity care in aged bad debt accounts - may old bad debt accounts be reversed and reclassified as charity care? In a system of write-offs and reversals, this seems like a real possibility – especially considering the practice of "smoothing" costs so that the true answer is achieved over time. Another example of "smoothing" in reimbursement is in the wage index – providers report salaries from the general ledger (accrual-based accounting) and hours associated with paid salaries from the payroll file (cash-based accounting).[10]

Ultimately, the ability to reclassify bad debt accounts may come back to how the amounts relate to a hospital's financial statement in prior years. A reclassification of bad debts may require a restatement of financial statements. For optimization of Uncompensated Care DSH payments, these efforts certainly can be worth the time and resources.

Recommendation: Hospitals are encouraged to evaluate prior year bad debt write-offs to determine if any amounts are truly charity care.

Short Term Hospital Services Only

CMS's proposal shifting Uncompensated Care DSH to only recognize short-term hospital services is a major change, especially for safety net hospitals providing essential sub-acute care services to low-income patients (e.g., behavioral health, rehabilitation, SNF, etc.). Providers with subacute care need to prepare for significant decreases in Uncompensated Care DSH payments, estimated to be effective in FFY 2025. This change emphasizes the importance of identifying all other uninsured costs, as discussed throughout this article. In FFY 2021, providers with subacute care received $5.3bn (63%) of the $8.3bn in national Uncompensated Care DSH funding.

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Recommendation: Hospitals providing subacute care,[11] billed under a CMS Certification Number (CCN) apart for the Hospital CCN, should evaluate the portion of uncompensated care cost (Charity and Bad Debt), as well as the cost-to-charge structure, to determine the amount of uncompensated care cost CMS is proposing to exclude from future Uncompensated Care DSH payments. This information can help hospitals prepare for this a potentially large swing in Medicare reimbursements.

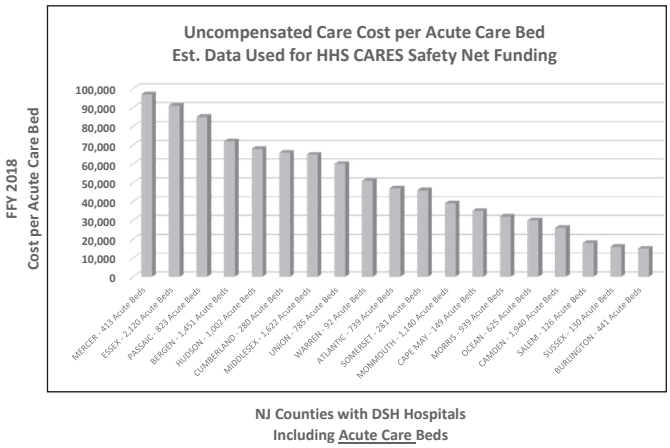
Uncompensated Care DSH and COVID-19

There is no doubt COVID-19 has changed access to healthcare and the amount of uncompensated care provided during 2020 and 2021. Under CMS's current method, these years would be the baseline driving Uncompensated Care DSH payments in FFY 2024 and FFY 2025. However, the data is atypical and with an uncertain future, recognizing these uncompensated care costs comes with consequences. For instance, there will be variation in the amount of uncompensated care delivered at hospitals in states with longer stay at home mandates vs. hospitals in states with-out these restrictions (or less restrictions).

Recommendation: As the industry moves forward, we should do so with caution, carefully evaluating the appropriateness using data from the public health emergency. Last Federal Year, FFY 2020, CMS applied a COVID related adjustment to Uncompensated Care DSH, using a more current estimate of unemployment in determining "Factor 2," resulting in an additional $500M in national funding.

Providers should also carefully assess all information reported on the Medicare cost report. As evident in the HHS CARES fund, even filed cost report information (before audit) from any Worksheet may be used to benchmark and prioritize funding need. For instance, consider HHS' application of FFY 2018 uncompensated care data used to determine CARES safety net funding. One of the "gates" to qualify for payment is an uncompensated care cost per (acute) bed equal to or greater than 25,000, and for many hospitals this determination was made from filed FFY 2018 cost reports. Listed below is a breakdown of this measurement by County for New Jersey DSH hospitals.

Lastly, the ACA mandates Uncompensated Care DSH is based on "appropriate data" or other "alternative data" that is "a better proxy for the costs. . . of treating the uninsured." As we adapt to life during and after COVID-19, the industry may also have to discover the alternative data that best measures uncompensated care provided during this extraordinary time.



About the author

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Footnotes

[1]Federal Registers, Vol 85 No 218 | Proposed Form CMS-2552-10 Transmittal 17 at https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-2552-10

[2]Accounting Standards Update, Topic 606

[3]Reported on Worksheet S-10 Line 20, Column 1

[4]Reported on Worksheet S-10 Line 20, Column 2 and Line 25.01 Column 1

[5]FFY 2021 IPPS Final Rule

[6]Charges reduced by the cost to charge ratio.

[7]Provider would report $195,000 in charges, netting to approximately $45,000 in uncompensated care cost.

[8]Accounting Standards Update, Topic 606.

[9]Scheduling showing bad debts relationship in accounts receivable at the beginning of the hospital fiscal year vs. the end of the fiscal year.

[10]Per CMS 2552-10 instructions for wage index - "Although this methodology does not provide a perfect match between paid costs and paid hours for a given year, it approximates a match between costs and hours."

[11]Billed under a CMS Certification Number (CCN) apart from the Hospital CCN

COVID-19 Coding: Reimbursement Opportunities, Shortfalls, and Supporting Your Staff

Tom Risi

Nick Altvater

by Tom Risi, CCS and Nick Altvater, CCS

The unprecedented COVID-19 global pandemic prompted equally unprecedented ICD-10 coding changes and demands on Health Information Management professionals: off-schedule releases of new codes and coding guidelines. HIM, IT, and revenue cycle professionals admirably adjusted to this "new normal" – including switching to primarily remote work. As staff have adapted, ensuring access to proper information and resources remains critical in optimizing new revenue opportunities in an evolving coding landscape.

As doctors and other medical professionals devised novel strategies to combat COVID-19, coders and HIM staff also navigated new ICD-10 codes that more accurately identify these new diagnoses and treatments. For the first time, CMS and the CDC issued off-schedule emergency ICD-10 updates outside of the normal October 1st implementation of coding changes. Existing diagnosis and procedure code options failed to adequately capture these conditions and treatments related to COVID-19.

With COVID-19 reducing inpatient admissions by a projected 10.5% for 2020[1] with no imminent changes in sight, how can hospitals ensure appropriate reimbursement despite shrinking volume? The recent off-schedule code releases from April 2020 through January 2021 continue to provide opportunities for more accurate data collection and additional reimbursement for treating hospitals. The following are some important highlights for revenue cycle, coding, and HIM professionals to keep in mind:

New ICD-10 Coding & Guideline Spotlight

- COVID-19 (U07.1)
  - Effective April 1, 2020 ICD-10 diagnosis code U07.1 (COVID-19) for COVID-19 was released, replacing interim code B97.29 (Other coronavirus as the cause of diseases classified elsewhere) – with additional reimbursement linked to this new code.
  - Correct assignment of U07.1 corresponds to a 20% increase to the DRG weight for payment purposes for COVID-19 Medicare Part A MS-DRG admissions.
  - Sequencing instructions for U07.1 have the potential to impact DRG assignment and reimbursement, particularly for mechanically ventilated patients.
- Remdesivir (XW033E5 and XW043E5)
  - Effective August 1, 2020, additional ICD-10-PCS codes were created to further capture new treatments to combat COVID-19 infections. Notably, this off-schedule update enabled hospitals to assign codes for the administration of the experimental anti-viral drug Remdesivir, an eligible New COVID-19 Treatments Add-On Payment NCTAP (NCTAP). CMS has clarified that for all discharges beginning on November 2, 2020, enhanced payment for eligible inpatient cases involving NCTAP will be the equal to the lesser of:
    - 65% of the operating outlier threshold for the claim; <u>OR</u>
    - 65% of the amount by which the costs of the case exceed the standard DRG payment.
      - For Remdesivir acquired by the provider from the government at no additional cost to the provider, the ICD-10-PCS code should still be assigned but a charge for additional reimbursement should not be reported.[2]

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- Pneumonia due to COVID-19 (J12.82)
  - Effective January 1, 2021, additional ICD-10 diagnoses codes were created to capture COVID-19 related disease manifestations. This off-schedule update created a new ICD-10 diagnosis code J12.82 (Pneumonia due to coronavirus disease 2019) to specifically identify pneumonia due to SARS-CoV-2. This code replaces previous diagnosis code J12.89 (Other viral pneumonia)[3].
  - The new ICD-10 diagnosis J12.82 code holds greater weight in some All Payer Refined (APR) groupers and Severity of Illness (SOI) indicators, with the ability to yield appropriate increased reimbursement to cover increased COVID-19 treatment costs.
- Sepsis in COVID-19 Patients (A41.89)
  - Changes to ICD-10 Coding Guidelines throughout the 2020 and 2021 year rewrote rules and instructions pertaining to proper code sequencing – resulting in potential changes in hospital reimbursement.
  - Recent Coding Clinics from the second quarter of 2020 permit assignment of A41.89 (Other specified sepsis) as a principal diagnosis if present on admission in COVID-19 patients[4]. Further Guideline changes provide additional instruction on proper sequencing of the new COVID-19 Pneumonia J12.82 code and other manifestations of COVID-19[5].
  - Sepsis sequencing guidelines impact reimbursement of mechanically ventilated COVID-19 patients.
    - Vent ≤ 96 consecutive hours with Sepsis A41.89 PDX: MS-DRG 871, Weight Factor 1.8682
    - Vent > 96 consecutive hours with Sepsis A41.89 PDX: MS-DRG 870, Weight Factor 6.4248
    - Vent ≤ 96 consecutive hours with U07.1 PDX: MS DRG 208, Weight Factor 2.5423
    - Vent > 96 consecutive hours with U07.1 PDX: MS DRG 207, Weight Factor 5.7264

Understanding These Changes

With all these changes, it remains important for revenue cycle, coding, CDI, and HIM professionals to understand the financial implications of these new off-schedule code implementations.

The administration of drugs in an inpatient setting can be captured comprehensively with a multitude of ICD-10-PCS codes. It is Health/ROI's experience that procedure codes for drug administration were inconsistently assigned at hospitals even prior to the pandemic. A number of factors can impact a facility's ability to correctly capture and code these new procedures:

- Internal hospital policies that limit ICD-10 procedure coding for drug administration may leave an organization at risk for under payment, given the unique nature of COVID-19 and treatment – such as with the new drug Remdesivir.
- Health/ROI's experience has shown that DRG editing software often overlooked these records because they were not designed to prompt reviewers or CDI professionals to look for medication administrations.
- When new code sets and guidelines are released outside of the regular October 1st updates, it is paramount for HIM staff to be educated in both the application of new codes and the impact on hospital revenue.

Outside of MS-DRGs and ICD-10 PCS codes, new opportunities arose impacting APR-DRGs and SOI indicators that differed from previous instruction. New ICD-10 diagnosis code J12.82 has increased the SOI level under APR Grouper Version 34 used by New York and New Jersey. Whereas the previously utilized code J12.89 (Other viral pneumonia) carried a secondary diagnosis SOI level of 2, the newly created code J12.82 for COVID-19 Pneumonia carries an increased SOI value of SOI 3 or 4. This increases the likelihood of an overall higher APR-DRG reimbursement to recognize some of the increased costs of treating these patients.

This means hospitals should receive additional reimbursement for the same COVID-19 patient with viral pneumonia with the same length of stay in 2021 than it did in 2020 if the appropriate ICD-10 codes are assigned. Health/ROI's experience has found that improper assignment of J12.89 instead of J12.82 is an issue that continues to persist months beyond the January 1st implementation, even at healthcare organizations that utilize multiple levels of internal and external DRG validation. It bears repeating that it remains crucial for coders and HIM staff to be educated properly on the release of off-schedule code additions and their potential implications for the hospital.

Overcoming Remote Work and Technology Barriers

Since early 2020, healthcare organizations have faced reduced revenue while navigating the challenges of transitioning to a hybrid workforce of remote and in-person staff. Changes in staff engagement and team communication raise a few chief concerns:

- How do we not only sustain operational functions at a pre-pandemic level, but communicate efficiently among and between teams to navigate a rapidly changing healthcare landscape?
- How do we encourage a remote coder or staff member who first notices a sudden change in SOI level to bring it to their HIM manager?

Consistent and open dialogue between HIM, revenue cycle, IT, and HIM managers could spell the difference between incorrect coding and proper reimbursement.

How Can You Help to Achieve Accurate Reimbursement?

With the complexity of an evolving pandemic and remote work arrangements, there are some strategies to help ensure accuracy while supporting staff:

- Open communication. Keeping lines of communication open between HIM staff, IT staff, and Revenue Cycle remains critical in a new remote-work environment with frequent changes.
- IT updates. Keeping coding software, grouper versions, and coding conventions up-to-date is essential in helping HIM professionals ensure proper encoding of records and reimbursement. If implementation of grouper updates to encoder and billing systems lags behind the release of the updates themselves, the hospital remains vulnerable to leaving unrealized revenue on the table.
- Continuing education. HIM professionals must also update their own knowledge and application of ICD-10 guidelines to meet the challenge of coding an evolving disease.

We are at a time when hospitals are grappling with overwhelmed ICUs, reduced elective procedures, and making ends meet despite financial shortfalls. Support of the crucial work and interdependence of the HIM, Revenue Cycle, and IT departments remains indispensable in fostering the sustainability of our hospitals.

About the Authors

Tom Risi, CCS and Nick Altvater, CCS are revenue recovery auditors at Health Resources Optimization Inc. Health/ROI specializes in DRG verification, denial management, cost outlier, transfer methodology, and APC recovery for multiple hospitals throughout New Jersey and the greater NYC metropolitan area. Tom and Nick can be contacted at trisi@health-roi.com and naltvater@health-roi.com

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•Focus on Finance•

American Hospital Association Releases Its Most Recent Community Benefit Report Applicable To Tax-Exempt Hospitals

By Hayley Shulman and Bill Hemmer

Hayley Shulman

Q. What information was released within the 2017 AHA Community Benefit Report that my hospital organization can use for national benchmarking?

A. Since 2012, the American Hospital Association ("AHA") (with assistance from EY) has published and released an annual report summarizing community benefits provided by tax-exempt hospitals, as reported on the Internal Revenue Service ("IRS") Form 990, Schedule H.

In its most recent report released in July 2020, AHA contracted with Guidestar to create a file of all electronically submitted Schedule H forms reported by tax-exempt hospitals in the 2017 tax year.

According to the AHA 2017 Report, a total of 2,383 Schedule H's were included, representing 2,764 hospitals in total. Together, these tax-exempt hospitals accounted for over $100 billion in benefits provided to the community during 2017.

Background

Tax-exempt hospitals file a Federal Form 990 annually, wherein they report their community benefit activities and associated estimated costs on Schedule H Part I. The Schedule H Part I incorporates the Catholic Health Association ("CHA") general principles for community benefit rules and regulations.

IRS Form 990 Schedule H, Part I; Community Benefit

The AHA report found that hospitals spent an average of 10.3% of total expenses attributable to community benefit under the IRS definition, commonly referred to as the "community benefit percentage". This information is summarized on Schedule H Part I, and includes the expense of providing financial assistance at cost, subsidizing Medicaid underpayments, funding community health improvement services, underwriting health professions education, funding health research, subsidizing certain health services, and making cash/in-kind contributions for community benefit. Note that these expenses and resultant percentages are reported net of any associated offsetting revenue.

Bill Hemmer

This information is further broken down within the AHA Report by hospital size, location, and type. For all categories, the majority of community benefit expense is derived from providing financial assistance, subsidizing Medicaid payments, and the unreimbursed costs from other means-tested government programs.

The AHA report also expands beyond the CHA and IRS definition of community benefit and provides information with respect to "total benefits to the community". Total benefits to the community include:

- Schedule H, Part I (financial assistance and certain other community benefits);
- Schedule H, Part II (community building activities); and
- Schedule H, Part III (Medicare shortfall and bad debt attributable to financial assistance).

Additionally, the report provides further detail by hospital segment (size, location and type).

Size: Hospitals were then categorized by size (in terms of expenses) as follows:

- Small hospitals – less than $100 million in total hospital expenses

Hospital Category	Financial Assistance, Unreimbursed Medicaid, Unreimbursed Costs From Means-Tested Government Programs	Health Professions Education	Medical Research	Cash And In-Kind Contributions to Community Groups	Other	Total Financial Assistance And Other Community Benefits
All Filed Schedule Hs (2,764 hospitals)	6.4%	1.7%	0.5%	0.3%	1.4%	10.3%

- Medium hospitals – $100 million to $299 million in total hospital expenses
- Large hospitals – more than $300 million in total hospital expenses

Location: Hospitals were categorized as "Urban/Suburban" or "Rural"

Type: Hospitals were categorized by type as either a General Medical, Children's, Teaching or Critical Access hospitals. Note: a single hospital can be in more than one "type" category.

Total Benefits to the Community

For the 2017 tax year, tax-exempt hospitals on average incurred approximately 13.8% of their total annual expenses on "benefits to the community", which is comprised of the following:

Hospital Category	Financial Assistance, And Certain Other Community Benefits	Community Building Activity	Medicare Shortfall	Bad Debt Expense Attributable to Financial Assistance	Total Benefits to the Community
All Filed Schedule Hs (2,764 hospitals)	10.3%	0.1%	3.1%	0.3%	13.8%

Size:

The data shows that the average total benefits to the community increased with the size of the hospital. Small hospitals incurred an average of 11.6% of their total expenses on benefits to the community, medium hospitals incurred an average of 12.6%, and large hospitals incurred an average of 14.1%. For medium hospitals, this increase was largely attributable to a higher Medicare shortfall, whereas, for large hospitals this increase was attributable to an increase in financial assistance and other community benefits.

Hospital Size	Financial Assistance, And Certain Other Community Benefits	Community Building Activity	Medicare Shortfall	Bad Debt Expense Attributable to Financial Assistance	Total Benefits to the Community
Small	8.9%	0.1%	1.9%	0.8%	11.6%
Medium	8.8%	0.1%	3.2%	0.5%	12.6%
Large	10.9%	0.1%	2.8%	0.3%	14.1%

Location:

Demographics typically impact a hospital's community benefit and total benefits to the community. Data from the 2017 report showed that total benefits provided to the community for Urban/Suburban hospitals was 3.5% higher than total benefits provided by Rural hospitals.

Hospital Location	Financial Assistance, And Certain Other Community Benefits	Community Building Activity	Medicare Shortfall	Bad Debt Expense Attributable to Financial Assistance	Total Benefits to the Community
Rural	8.0%	0.1%	1.4%	0.6%	10.1%
Urban/Suburban	10.4%	0.1%	2.8%	0.4%	13.6%

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Type:

The report indicated that Critical Access hospitals incurred an average of 9.7% of their total expenses on benefits to the community, whereas General Medical hospitals incurred an average of 13.3%, Teaching hospitals incurred an average of 13.6% and Children's hospitals incurred an average of 15.9%.

Hospital Type	Financial Assistance, And Certain Other Community Benefits	Community Building Activity	Medicare Shortfall	Bad Debt Expense Attributable to Financial Assistance	Total Benefits to the Community
General Medical	9.9%	0.1%	2.9%	0.4%	13.3%
Children's	15.5%	0.1%	0.2%	0.1%	15.9%
Teaching	10.7%	0.1%	2.5%	0.3%	13.6%
Critical Access	8.3%	0.1%	0.8%	0.6%	9.7%

Children's hospitals had a substantially higher percent of community benefit expenses when compared to the other hospital types which is typically attributable to a higher rate of unreimbursed Medicaid. In addition, the report indicated that children's hospitals spent an average of 2% of their total expenses on medical research, which was higher than any other hospital type.

Bad Debt Expense

The report found that 47% of the 1,931 individual hospital Schedule Hs reported bad debt expense attributable to the organization's financial assistance policy. A majority of hospitals reported that some portion of their bad debt expense would qualify as community benefit had the patient completed the hospitals' financial assistance processes and provided the requisite financial and other information.

Medicare Surplus and Shortfall

Approximately 71% of hospitals reported having a Medicare shortfall on Part III, Section B of Schedule H. This shortfall, which accounted for 3.1% of hospital expenses in 2017, occurs when the Federal government reimburses hospitals at less than their costs for treating Medicare patients.

Community Building Activities

Individual hospitals and systems reported an average of 0.1% of their total expenses on community building activities. These activities include, but are not limited to, workforce development, environmental improvements, and hospital employee participation on state Boards of Health, regional health departments, neighborhood community relations committees, and with university and other school partnerships.

Conclusion

The AHA's 2017 Schedule H report is a useful resource available to all hospitals which can be used to benchmark and compare a hospital to national averages. While this report allows for quick comparisons, it is important to note that each hospital has a different set of facts and circumstances to consider, including size, location and hospital type, which can affect its community benefit percentage in relation to its peers.

The IRS, Department of Health, state and local regulators as well as the general public all utilize Guidestar and other publicly available information to review total benefits provided to the community by hospital organizations. In addition, throughout the COVID-19 pandemic and prospectively, community benefit, hospital operations/activities, and reporting transparency will continue to be important areas of focus for everyone associated with a hospital's Form 990, Schedule H.

Current year Form 990 Schedule H planning considerations

Properly identifying and quantifying all of a tax-exempt hospital's community benefit activities and programs remains critically important today for Federal, state, and local tax-exemption purposes. Withum recommends the following on at least an annual basis:

1. Form an internal Form 990 Schedule H community benefit working group
2. Compare and benchmark your tax-exempt hospital's community benefit to the AHA report nationally
3. Compare and benchmark your tax-exempt hospital to its state and local tax-exempt hospital peer group
4. Communicate your respective hospital's Schedule H community benefit information and benchmarks to your board, audit committee, and members of senior management
5. Communicate your community benefit information to the general public, including consideration of preparing and posting a community benefit report on your website

Moreover, year 2020 was unprecedented due to COVID-19; we recommend that hospital organizations identify and capture all additional community benefit activities and programs and related costs associated with the COVID-19 pandemic. While additional guidance is forthcoming, please refer to Withum's COVID-19 and Schedule H community benefit update, which highlights the preliminary general guidance released by the CHA for reporting community benefits related to COVID-19. Lastly, start planning early, as experience shows Schedule H community benefit programs and reported costs are typically higher with advanced planning and preparation.

For more information on this topic, please contact a member of Withum's Healthcare Services Group.

COVID-19's Impact on Hospitals Is More Than Financial as Volume Reductions Continue

Roger Sarao

by Roger Sarao

The number of patients going to New Jersey hospitals for care or procedures continues to be dramatically below pre-pandemic levels. Significant decreases in patient activity are present across all settings, raising concerns about the potential impact on residents' health and the financial and operational challenges for hospitals and other healthcare providers as an anticipated post- COVID rebound remains uncertain.

This bulletin examines hospital data through the third quarter of 2020, ending Sept. 30, 2020. It continues a quarterly review of hospital utilization and financial data first provided last October by NJHA's Center for Health Analytics, Research & Transformation (CHART).

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

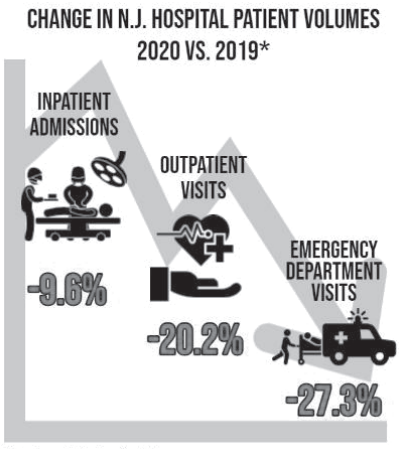
- Hospital emergency department cases plummeted 27 percent.
- Outpatient visits dropped by 20 percent.
- Inpatient admissions decreased 9.6 percent.
- Total expenses jumped 10 percent.
- Patient revenues and average operating margins declined.
- The percent of hospitals posting operating losses nearly doubled.

These findings show the continuing effect of COVID-19 on hospital finances and patient volumes. Relief aid from federal legislation such as the Coronavirus Aid, Relief, and Economic Security (CARES) Act to hospitals in New Jersey and throughout the nation has not erased the financial strain as hospitals continue to care for patients and play a leading role in vaccinating their staffs and communities.

Of the $175 billion of Provider Relief Fund payments appropriated by the CARES Act, roughly $103 billion has already been paid to more than 400,000 hospitals, nursing homes, clinics and other healthcare providers throughout the nation. According to federal data updated through Jan. 27, 2021, nearly 16,500. New Jersey providers have collectively received $4.3 billion in Provider Relief Fund payments.

Despite this short-term federal relief, as of Sept. 30, 2020, the proportion of New Jersey hospitals operating "in the red" (with net revenues insufficient to cover operating expenses) was 41 percent – nearly twice the percentage just one year ago (22 percent).

Volume Indicators



The ongoing reductions in patient volumes across all settings – inpatient admissions, outpatient visits and emergency department visits – compared with pre-COVID-19 levels, continue to adversely impact the fiscal health of the state's hospitals.

With inpatient admissions accounting for more than half of all patient revenues, even a modest reduction in volume can wreak havoc on hospital budgets. Through the third quarter of 2020, inpatient admissions were 9.6 percent lower than admissions through the same period in 2019. The falloff in outpatient visits was even greater over the same period, declining 20.2 percent in 2020 compared to 2019.

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The most dramatic reductions in volume, however, were seen in the emergency department setting. Through Sept. 30, year- to-date emergency department visits were 27.3 percent lower in 2020 than last year. These figures exclude visits that resulted in the patient being admitted to the hospital, as such patients are captured in the inpatient totals.

Financial Performance

A hospital's fiscal performance is inextricably linked to patient volumes. To better understand the industry's overall financial status, this analysis first examined revenues and expenses independently. Comparisons to historical levels were made by calculating the average amount of expenses incurred – and net patient service revenue (NPSR) received – for all services provided to patients across any setting. The resulting "per adjusted admissions" metrics were then adjusted for case mix intensity (CMI) – the average severity of all patients treated at each hospital.

For the pre-COVID period year-to-date Sept. 30, 2019, the statewide average total expenses per adjusted admission, after adjusting for case mix, was $11,298. One year later, after more than six months of costly pandemic response activity across the state, average hospital expenses increased 10 percent, to $12,413 per adjusted admission.

While less extreme, the change in average revenues continued the downward trend observed earlier in the year. The nine- month average for total NPSR per adjusted admission was $10,899 in 2019 (also adjusted for case mix). By Sept. 30, 2020, statewide revenues fell to $10,613 (a decrease of 2.6 percent compared to 2019).

This increase in expenses, coupled with a decrease in revenues, is reflected in the statewide average operating margin. Through three-quarters of 2020, the average margin for New Jersey hospitals was 1.6 percent, less than half of the 3.6 percent average margin one year earlier. Similarly, the percent of hospitals ending the period with a negative margin, or "in the red," nearly doubled – from 22 percent in Q3 2019 to 41 percent in Q3 2020.

This real decline in average operating margin persisted despite the influx of federal relief received through the Provider Relief Fund provisions of the CARES Act. According to the American Hospital Association, this funding falls far short of covering hospitals' losses. As noted above, hospitals and other providers have received only a little over half (59 percent) of total relief funds available under the Act. Without the Provider Relief Fund payments already allocated to New Jersey hospitals, the 2020 statewide average operating margin would be even lower.

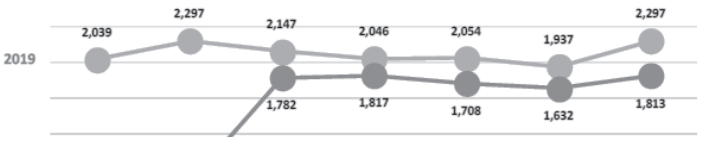
Update on Elective Procedures

The ongoing declines in patient volume across all hospital settings as of Sept. 30, 2020, continue to raise concerns about residents avoiding or delaying visits to their community hospital for certain healthcare services during the pandemic. In the mid-year report, CHART reviewed claims-level data for six common inpatient elective procedures (Bariatric Sleeve Gastrectomy, Pacemaker Insertion, Spinal Fusion, Right Knee Replacement, Left Knee Replacement, and Hernia Repair) performed both during and immediately after the two months the statewide ban on electives was in effect.[1]

As expected, the volume for these selected procedures in the two months (June and July) immediately following the ban increased from the two months the ban was in place (April and May). However, when compared to the same months from one year earlier, it was clear that fewer procedures were being scheduled and performed in 2020.

In an updated analysis, CHART reviewed the claims data for the same six inpatient elective procedures for the five-month period following the rescinding of the ban (June through October 2020) compared to the same months in 2019. The results reaffirm the initial findings: While more electives are being performed than during the state-mandated ban, the number of procedures is substantially less than that from one year ago.

Statewide Totals for Six Common Inpatient Elective Procedures Performed at New Jersey Hospitals



As shown in the graph above, volume for the inpatient elective procedures included in the study began to rebound in June – the first full month after the ban was lifted on May 26, 2020 – yet lagged behind 2019 levels by approximately 17 percent. In July the gap had closed to within 11 percent of prior year volume. But August and September saw a return to June levels, with 2020 monthly volumes at just 83 percent and 84 percent, respectively, of 2019 levels. It should be noted that the apparent decline in October activity may be overstated as a result of the inherent lag between the date of service for a given procedure and the date the claim for that service is reflected in the statewide hospital dataset. Nonetheless, it appears that a full rebound to historical levels of elective volume may be months away.

An alternate takeaway from these ongoing volume reductions in inpatient elective procedures – and more globally in overall admissions, outpatient visits and emergency department activity – is that hospital patient visits may not return to pre-COVID levels for the remainder of year. The possibility that

the low volume levels currently presenting at New Jersey hospitals become the new "volume baseline" for 2021 must be considered. In fact, such a conclusion was reached by TransUnion Healthcare in a new study published last month. Based on data from more than 500 hospitals nationwide, the analysis found that inpatient admissions from June through December 2020 were down 7 percent compared to the same period in 2019, and emergency department visits were down 22 percent. These reductions are not dissimilar to the experience of New Jersey hospitals as discussed in this report.

The national study predicts that hospitals will likely see continued volatility in patient visit volumes over the next 12 months. Hospitals in New Jersey have already begun the process of adapting to treating fewer patients during the COVID-19 pandemic. Based on the recent statewide and national data, continued contingency planning throughout 2021 in anticipation of extended volume reductions should be considered.

About the author

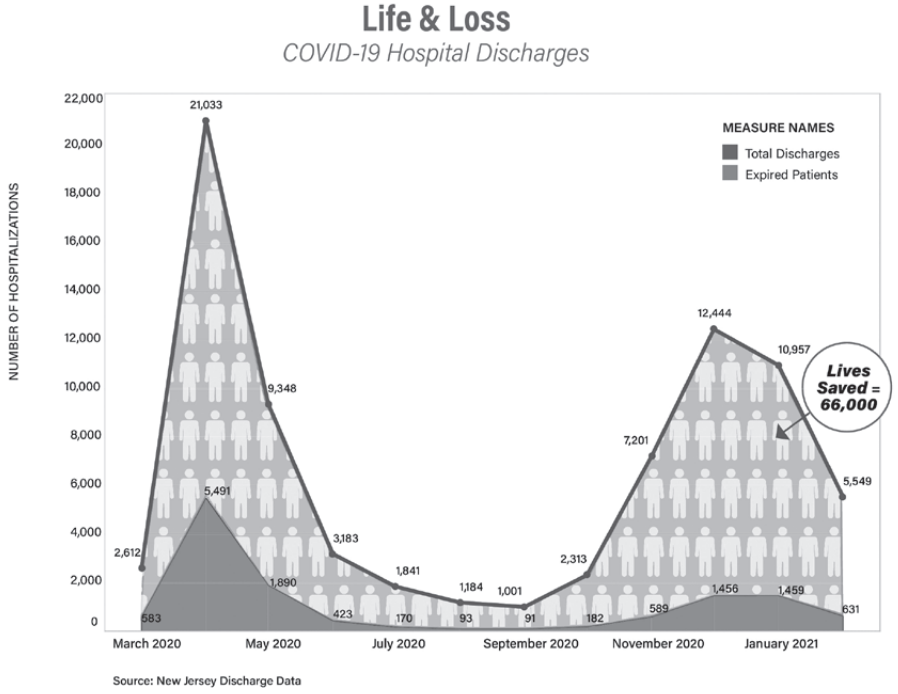
Roger Sarao is the Vice President of Health Economics & Policy for the Center for Health Analytics, Research & Transformation (CHART) at the New Jersey Hospital Association. CHART was launched in August 2018 to provide healthcare stakeholders, policy experts and the community at large insightful data analytics and predictive modeling to address some of the state's greatest healthcare challenges. Mr. Sarao also serves as an ex-officio member on the Board of Directors of the New Jersey Chapter of the Healthcare Financial Management Association. He can be reached at rsarao@njha.com.

Footnote

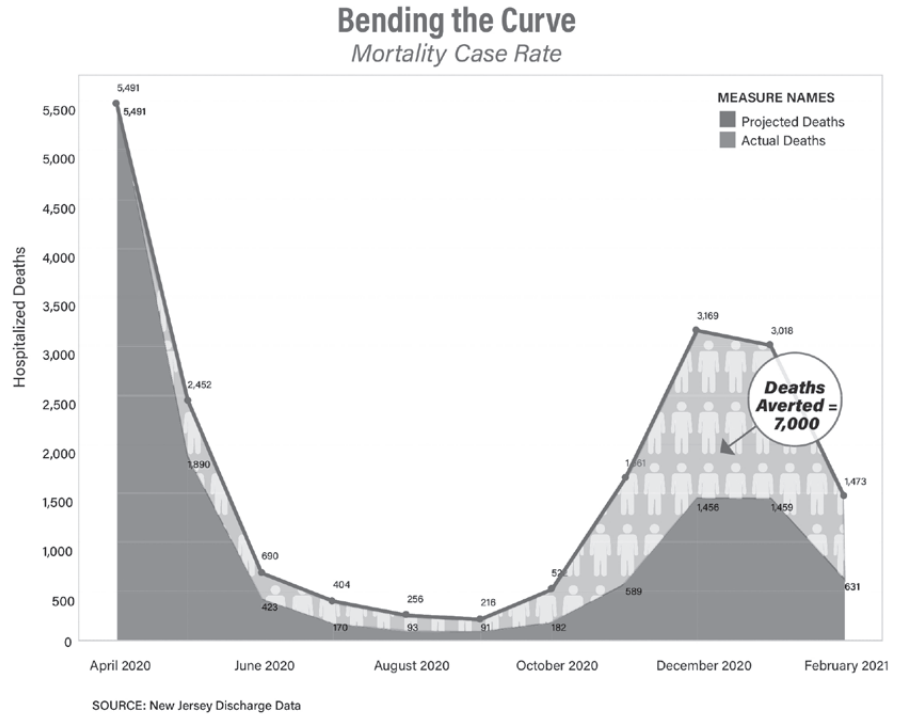
[1]Gov. Murphy's Executive Order 109, which called for a suspension of medical and dental "elective" procedures during the COVID-19 response, was in effect from March 27 through May 26, 2020. In order to simplify the discussion about volume trends, CHART considered the months of April and May 2020 in their entirety to represent the two-month period the ban was in effect, even though it began in late March and ended in late May. The order defined an elective procedure as "any surgery or invasive procedure that can be delayed without undue risk to the current or future health of the patient as determined by the patient's treating physician or dentist.

Loss, Lessons, Lives Saved

"As New Jersey enters the second year of pandemic, a new report from the New Jersey Hospital Association shows the life-saving outcomes of New Jersey hospitals: More than 66,000 lives saved among patients with severe COVID disease who were discharged successfully, including 7,000 projected deaths averted as hospitals improved treatment and outcomes to reduce COVID mortality. The following graphs show the improved outcomes as N.J. hospitals bent the mortality curve. For more findings and data, go to http://www.njha.com/chart/special/pandemic/."



Courtesy of New Jersey Hospital Association



Courtesy of New Jersey Hospital Association

An Overview of the Corporate Transparency Act

Megan R. George

by Megan R. George, Esq.

The Corporate Transparency Act (CTA), a segment of the larger National Defense Authorization Act for Fiscal Year 2021, was enacted into law on January 1, 2021. The legislative intent of the CTA is to combat money laundering through enhanced reporting requirements to the U.S. Department of Treasury's Financial Crimes Enforcement Network (FinCEN).

The CTA applies to corporations, limited liability companies and "other similar entities" formed within any state or territory of the U.S., or in foreign entities that are registered to do business in the U.S. (Reporting Companies). Certain entities are not considered Reporting Companies for purposes of the CTA, including (i) entities that are closely regulated (i.e., banks); (ii) publicly traded companies; (iii) dormant entities; (iv) tax exempt entities; (v) entities owned or controlled by an entity that is exempt; and (vi) taxable entities that (a) have more than 20 full time U.S-based employees (b) have a physical office in the U.S., and (c) have more than $5 million in gross receipts or sales.

Reporting Companies are required to disclose their beneficial owners to FinCEN via a beneficial ownership statement. A beneficial owner is defined in the CTA as an individual who directly or indirectly "exercises substantial control over the entity" or "owns or controls not less than twenty-five percent of the ownership interests of the entity."

The U.S. Department of Treasury will adopt regulations to correspond with the CTA. These regulations will likely contain information regarding how to measure ownership and determine who is in control of the Reporting Company. Regulations are also expected to address multi-tiered companies, related parties, and whether those acting as agents on behalf of the Reporting Company will be required to disclose. It is anticipated that the regulations will also contain rules regarding supplemental reporting for a change in ownership or changes in control.

The information that must be disclosed to FinCEN through the beneficial ownership statement is as follows:

- Full legal name of each beneficial owner
- Current residential or business street address of each beneficial owner
- The beneficial owner or owners' date of birth
- The beneficial owner or owners' identification number in the form of either a driver's license number or passport number

The beneficial ownership statements submitted to FinCEN are not publicly available and are to be accessible only to the government for national security, law enforcement, and intelligence purposes. Upon receiving consent from the Reporting Company, financial institutions may be permitted to access the beneficial ownership statements of a customer to facilitate compliance with the financial institution's customer due diligence requirements.

Under the CTA, Reporting Companies that are formed on or after the date that the regulations are adopted will be required to submit a beneficial ownership statement upon formation. Reporting Companies that were in existence prior to the issuance of final regulations will have two years from the issuance of final regulations to submit a beneficial ownership statement to FinCEN.

The CTA imposes financial penalties for Reporting Companies that intentionally fail to comply with the requirements of the CTA, including the filing of false information. Parties who violate the requirements of the CTA are also subject to imprisonment. The CTA provides a safe harbor for those who submit incorrect information so long as such person can prove that (i) they had no knowledge of the inaccuracy; (ii) they were not knowingly trying to evade the requirements for the CTA; and (iii) the information is corrected within 90 days of the initial filing.

The CTA is likely to take effect in early 2022, following the adoption of the Treasury Department's corresponding regulations. Companies should familiarize themselves with the reporting requirements in order to appropriately prepare for compliance in a timely fashion.

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Virtual Care - Telehealth Before and After Covid-19

Michael McLafferty

by Michael McLafferty CPA, MBA, FACHE, FHFMA, FACMPE

Virtual care is a broad term that encompasses all the ways healthcare providers remotely interact with their patients. In addition to treating patients via telemedicine, providers may use live video, audio, and instant messaging to communicate with their patients remotely.[5]

The Health Resources Services Administration (HRSA) defines telehealth as the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration. Telehealth is different from telemedicine in that it refers to a broader scope of remote health care services than telemedicine. Telemedicine refers specifically to remote clinical services, while telehealth can refer to remote non-clinical services.[5]

Telehealth before COVID-19 was limited in its originating sites, services offered and low reimbursement. The combination of reduced access, few service offerings and low payment severely limited the use of telehealth as a medical option for most patients.

Telehealth initiatives provided a platform to combat the shortcomings of cost, quality, and accessingrained in American health care. The breadth of telehealth services includes remote clinical health care, patient and professional health-related education, public health, and health administration via electronic information and telecommunication technologies. Health-care delivery services are also integrating artificial intelligence (AI) systems into the suite of telehealth services, as both doctors and patients move from solely remote patient monitoring for continuous recording of vital signs to real-time alerts from a patient sensor when there is a deteriorating change incondition.[1]

During January–March 2020, most telehealth patients (93%) sought care for conditions other than COVID-19. However, the proportion of COVID-19–related encounters grew (from 5.5% to 16.2%) during the last 3 weeks of March, when an increasing number of visits included mention of COVID-19 in the "reason for visit" field. In addition, 69% of patients who had a telehealth encounter during the early pandemic period in 2020 were managed at home, with 26% advised to seek follow-up from their primary care provider as needed or, if their condition worsened or did not improve, 1.5% were advised to seek care in an ED, and 3% were referred to an urgent care setting.[4]

A better understanding of the details for current telehealth coverage during the Public Health Emergency (PHE) can be seen in the following Before vs. After COVID-19 CMS Original Medicare Fee for Service analysis:

(1) Who has access?
   a) Before COVD-19 – Patients had to be in a remote or rural coverage area. In 2018, only about 21.5% of original Medicare beneficiaries resided in rural areas (7.8 Million).
   b) After COVID-19 – There are no restriction on coverage area. Now all 36 million* Original Medicare beneficiaries have access to the service.

(2) Can providers see patients from their homes?
   a) Before COVD-19 – Providers must be located in a Medicare eligible place of service, such as a clinic or hospital.
   b) After COVD-19 – There are no restrictions on practitioners furnishing telehealth services from their home.

(3) What services can you furnish via telehealth?
   a) Before COVD-19 – A limited number of services was approved to be delivered via telehealth with real-time audio and video.
   b) After COVID-19 – CMS has rapidly expanded the list of services that are temporarily allowable during the PHE. CMS is also allowing some services to be delivered via audio-only. A complete list of allowable telehealth and audio-only services is available on the CMS website.

(4) Are there technology restrictions?
   a) Before COVD-19 – Technology was required to be HIPAA compliant interactive audio and video telecommunications system that permits real-time communication between provider at the distant site, and the beneficiary at

the originating site. These technologies often required high up-front investment in platforms and hardware.

b) After COVID-19 – HIPAA regulations are not being enforced, which opens up a variety of apps and technologies that could be utilized while getting started in telehealth. The platform must support real-time audio and video, such as FaceTime, WhatsApp, and Facebook Messenger.

(5) Do patients have to pay for telehealth services?

a) Before COVD-19 – Cost sharing (deductible and coinsurance) applies for originating site fee and distant site services.

b) Healthcare providers now have the option to reduce or waive all cost sharing for telehealth visits provided under Medicare.

(6) Can patients receive telehealth services in their home?

a) Before COVID-19 – The offices of physicians and/or practitioners; a Hospital or a Critical Access Hospital (CAH); Rural Health Clinic (RHC) or Federally Qualified Health Clinic (FQHC); Hospital-based or CAH-based Renal Dialysis Centers (including satellites); Skilled Nursing Facility (SNF); and Community Mental Health Centers (CMHC).

b) After COVID-19 – CMS has waived restrictions on originating sites. Now, the patient can receive services in their own home.

(7) Do patients have to be established with a provider?

a) Before COVID-19 – Only patients who had already established a relationship with the provider could receive a telehealth visit.

b) After COVID-19 – New and established patients can be seen via telehealth.

(8) Do physicians and NPPs have to be licensed in every state?

a) Before COVID-19 – Providers had to be licensed in the state where they are located at the time of service as well as the state where the patient is physically located.

b) After COVID-19 – Medicare and Medicaid are temporarily waiving the requirement for providers to be licensed in the state where the patient is located, as long as they are appropriately licensed in another state. However, state restrictions may apply.

(9) Can RHCs/FQHCs Be the distant site?

a) Before COVID-19 – RHCs and FQHCs can only serve as Originating Site.

b) After COVID-19 – RHCs and FQHCs may be the distant site for telehealth visits. Practitioners may also furnish telehealth services from their homes.[2]

The COVID-19 pandemic propelled patients and physicians to quickly adopt telehealth and going forward the virtual visits could potentially account for $250 billion, or about 20%, of what Medicare, Medicaid and commercial insurers spend on outpatient, office and home health visits, according to a new Mckinsey and Company report. Before COVID-19 shut down the United States, telehealth accounted for an estimated $3 billion.[3]

Physicians and other health professionals are now seeing 50 to 175 times the number of patients via telehealth than they did before the pandemic. The report notes that 46% of patients are now using telehealth to replace canceled in-person visits, up from the just 11% of patients who used telehealth in 2019.[3]

The study identified five models for virtual or virtually enabled nonacute care: on-demand virtual urgent care, virtual office visits, near-virtual office visits, virtual home health services and tech-enabled home medication administration.

By shifting this care to telehealth, the authors estimated that:

- 20% of all emergency room visits could be avoided.
- 24% of health care office visits and outpatient volume could be delivered virtually and an additional 9% delivered "near-virtually."
- 35% of regular home health attendant services could be virtualized.
- 2% of all outpatient volume could be shifted to the home setting, with tech-enabled medical administration.[3]

Physicians need to be concerned about security, workflow integration, the future for telehealth reimbursement and effectiveness of telehealth visits compared to in-person visits. Patients will need to be educated as to the availability and the value of telehealth treatment. Without the constant reminder of a virtual service offering, telehealth visits may not continue to grow and provide patients with another option to be serviced by the physician.

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[3]After COVID-19, $250 Billion in Care Could Shift to Telehealth, Tanya Albert Henry, American Medical Association, June 18, 2020

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[5]Telemedicine vs. Virtual Care: Defining the Difference, Teledoc Health, Forum 2020

About the author

Michael McLafferty is CEO and Founder of MJM Advisory and Educational Services LLC. Healthcare executive and consultant with more than 30 years of experience servicing major healthcare systems, clinically integrated networks (CIN), Accountable Care Organizations (ACO), large physician organizations, ambulatory surgery centers, healthcare joint ventures and for-profit healthcare organizations. Facilitated administrative, operational and financial improvement for management. Led projects focused on merger/acquisition, cash flow improvement and regulatory compliance. Michael can be reached at michael@mjmaes.com.

Resilience is a Daily Habit

Wendell White

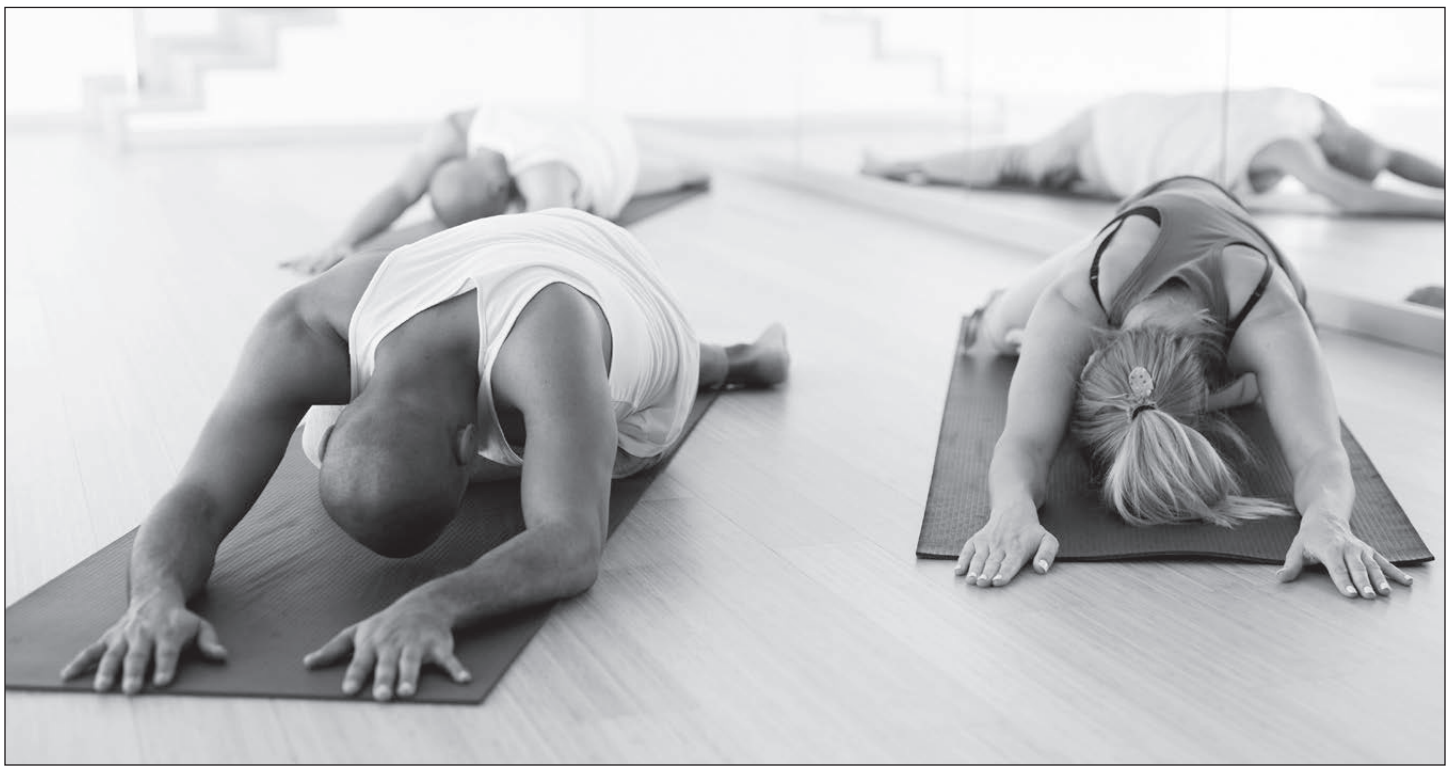
by Wendell White

The phrase "resilience is a habit" came to me a couple weeks ago while cold temperatures blanketed the southern United States, millions were without power and clean water on top of the already devastating impacts of the pandemic. The grim daily toll of new hospitalizations and deaths with accompanying suffering and grief, the physical separation, the economic toll of shuttered businesses and jobs, leaving millions in housing and food insecurity, felt especially overwhelming at that moment.

While our individual experiences have been different, we have all experienced some disruption, separation, and setbacks, during this past year. Many are grieving losses. Worldwide pandemics are thankfully rare, but each of us, each of the people you lead or work with, can have "pandemic level" challenges in their lives in "normal" times. Other more "normal" life challenges meet us daily, requiring emotional resilience to maintain our equilibrium. Emotional resilience-challenging episodes can originate in our personal or public spheres, but often spill over.

Though the literal definition of resilience emphasizes acquired strength through flexibility, give, and elasticity, we frequently misapply the concept of resilience. Equating resilience with stoicism in the face of extraordinary challenges or a short downtime with a hyper focus on the snapback is embedded in our culture. Check the Google images for resilience. Even in our workplace policies, for example, the three-days allocated for grief and only for immediate family, are emblematic of this concept. I understand the need for timekeeping policies, but time blocking grief helps to create an expectation that it's not OK to require more time. It also can be an awkward conversation for leaders to have with team members who are struggling.

The true essence of resilience is to repeatedly rebound from



setbacks. Consider more of the synonyms for resilience: flexibility, pliability, suppleness, plasticity, and elasticity. Resilience's definition parallels physical flexibility and like physical flexibility, requires repeated practices or habit. We achieve that emotional flexibility by repeating the good practices you have likely heard of for achieving balance.

- Make regular time for yourself
- Choose or form an intimate community of friends and stay connected
- Embrace physical and mental health
- Find or reignite a passion

While these good practices are well known, we fail in achieving them due to unreasonable expectations to make wholesale changes. Making time for yourself does not have to be an elaborate spa day, it could be as simple as a 10-minute meditation before bed or 10 minutes driveway decompression before entering your home. Physical health can start with committing to a 15-minute walk at lunch three days per week. We cannot successfully execute these habits at once. We must layer them over time. Build resilience habits into systems (e.g., with calendar appointments and checklists) until they become a part of who we are. And, when we drift from doing them, we should be gentle with ourselves and start again.

Leadership in the workplace is critical in this area as well. One of the ways leaders make a difference is by normalizing team members not feeling 10 out of 10 every day. Taking physical and emotional pulse checks at the beginning of your one-on-one meetings or small group meetings can be helpful. Leaders can gauge well-being through conversation or using a symbol or a score, like the pain scales or mental health scales we are familiar with from clinical encounters.

Some leaders shy away from this because they fear learning about something they cannot fix, or perhaps they don't believe its pertinent to the workplace. Pulse checks do not mean you have to solve the challenges or learn the details, but by asking, you begin to make it normal for them to communicate their challenges and by doing so, make it normal to address them. Leaders and colleagues can express empathy or compassion and/or direct them to resources and/or encourage them to take a break.

Finally, while small bursts of regular breaks for yourself are an essential habit, we all ultimately need a clean break. Many of us haven't taken any meaningful time to recharge since March 2020. Your time away may not be the milestone birthday trip you envisioned before the pandemic or the large family gathering at the beach but take some time anyway. The waiting for things to be normal could be making you emotionally tight. Your team and your colleagues need your full emotional resilience in this time, perhaps now more than ever.

About the author:
Wendell White and HealthRev Advisors create high performing leaders and teams that allow their clients to maximize revenue cycle value. Wendell is an innovator, speaker and principal for HealthRev Advisors, LLC. He lives in Richmond, VA.

•Certification Corner•

News from the National: HFMA's Digital Credential Provider Launches New Branding: Credly

HFMA works hard to provide you with all the tools for career success that we possibly can. That's one reason we issue digital credentials to recognize your *certification and course completions*. On March 31, 2021, HFMA's digital credential provider, Credly, launched a new visual experience on the platform currently known as Acclaim. This is the final step in merging the two brands. As part of that experience, the Acclaim name, logo, and URL has been replaced by Credly.

No action is required on your part, and the way you use the platform won't change. The one change you will see is that badge notification emails that used to come from @youracclaim.com will now come from @credly.com. The Credly team is looking forward to sharing their new brand with members, and we look forward to continuing to provide you with digital credentials that support your professional goals.

Email careerservices@hfma.org with any questions.

HFMA has a new online learning platform

Have you been to HFMA's learning platform recently? If not, go to hfma.org and check it out! Press My eLearning at the top of the page to browse the web - the user interface has been improved, with better course organization and navigation. Browse the latest course catalog, which is organized by subject type; the revised framework tailors learning paths and courses to your preferences. With your HFMA all-access membership, you'll have access to all of the online courses!

Answers to many of your questions, and tips on how to navigate can be found in the Online Learning Platform FAQs. You can also email inquiry@hfma.org. For all questions regarding certification, contact Amina Razanica, arazanica@njha.com.

•Who's Who in NJ Chapter Committees•

2020-2021 Chapter Committees and Scheduled Meeting Dates

***NOTE:** Committees have use of the NJ HFMA conference Call line.
If the committee uses the conference call line, their respective attendee codes are listed with the meeting date.

PLEASE NOTE THAT THIS IS A PRELIMINARY LIST - CONFIRM MEETINGS WTH COMMITTEE CHAIRS BEFORE ATTENDING.

COMMITTEE	PHONE	DATES/TIME/ ACCESS CODE	MEETING LOCATION
CARE (Compliance, Audit, Risk, & Ethics)			
Chair: Danette Slevinski – slevindl@uhnj.org	(516) 617-1421	First Thursday of the month	Conference Call
Co-Chair: Leslie Boles – lboles21@gmail.com	(732) 877-9864	9:00 AM	(712) 770-5393
Board Liaison: Lisa Maltese-Schaaf – LMaltese-Schaaf@childrens-specialized.org	(732) 507-6533	Access Code: 473803	
Communications / FOCUS			
Chair: Scott Besler (**Editor**) – scott.besler@toyonassociates.com	(888) 514-9312	First Thursday of each month	Conference Call (712) 775-7460
Board Liaison: Brian Herdman – bherdman@cbiz.com	(609) 918-0990 x131	10:00 AM Access Code: 868310	In-person Meetings by Notification
Education			
Chair: Hayley Shulman – hshulman@withum.com	(973) 898-9494	Second Friday of the Month	Zoom Meeting
Co-Chair: Sandra Gubbine – Sandra.Gubbine@atlanticare.org	(609) 484-6407	9:00 AM	
Co-Chair: Lisa Weinstein – lisa.weinstein@bancroft.org	(856) 348-1190	https://us02web.zoom.us/j/89425417190?pwd=aERLK0g3eUFIdlZXbXVJRTFJSVB0QT09	
Board Liaison: Hayley Shulman – hshulman@withum.com	(973) 898-9494		
Certification (Sub-committee of Education)		Second Friday of the Month	
Chair: Amina Razanica – arazanica@njha.com	(609) 275-4029	10:00 AM	Conference Call
Board Liaison: Hayley Shulman – hshulman@withum.com	(973) 898-9494	See education Zoom Link	
FACT (Finance, Accounting, Capital & Taxes)			
Chair: Alex Filipiak – Alexander.Filipiak@rwjbh.org	(732) 789-0072	Third Wednesday of each month	Conference Call
Co-Chair: Spiro Leunes – sleunes@bdo.com	(917) 816-0601	8:00 AM	(712) 770-4952
Board Liaison: Dave Murray – dmurray@rumcsi.org		Access Code: 294782	
Institute 2020			
Chair: Maria Facciponti – facciponti.maria@gmail.com	(973) 583-5881	Third Monday of each month	Conference Call
Co-Chair: Sandra Gubbine – Sandra.Gubbine@atlanticare.org	(609) 484-6407	2:00 PM	(712) 770-4957
Co-Chair: Brian Herdman – bherdman@cbiz.com	(609) 918-0990 x131	Access Code: 865290	
Board Liaison: Jill Squiers – Jill.Squiers@AmeriHealth.com	(609) 662-2533		
Membership Services/Networking			
Chair: Nicole Rosen – nrosen@acadia.pro	(862) 325-5906	Third Friday of each month	Conference Call (712) 770-5335
Co-Chair: John Byrne – JByrne56@gmail.com	(610) 737-6683	9:00 AM	In-person Meetings
Board Liaison: Heather Stanisci – hstanisci@ArcadiaRecovery.com	(862) 812-7923	Access Code: 267693	by Notification
Patient Access Services			
Chair: Daniel Demetrops – ddemetrops@medixteam.com	(845) 608-4866	February 11, March 11 & May 13, 2020	Conference Call
Co-Chair: Jacqueline Lilly – jacqueline.lilly@atlanticare.org	(609) 385-3105	at 4:00PM	(712) 770-5377
Board Liaison: Amina Razanica – arazanica@njha.com	(609) 275-4029	Access Code: 196273	In person Meetings by Notification
Patient Financial Services			
Chairman: Steven Stadtmauer – sstadtmauer@csandw-llp.com	(973) 778-1771 x146	Second Friday of each month	Conference Call (712) 770-4908
Co-Chair: Michael Berger – mberger10@comcast.net	(908) 794-8994	10:00 AM	In person Meetings
Co-Chair: Ruby Ramos – ruramos77@yahoo.com	(908) 884-7259	Access Code: 120676	by Notification
Board Liaison: Maria Facciponti – facciponti.maria@gmail.com	(973) 583-5881		
Payer/Provider Collaboration			
Chair: Michelle Merchant – Michelle_Merchant@horizonblue.com	(973) 466-4048	Third Wednesday of each month	Contact Committee
Co-Chair: Holly Fritz – holly.fritz04@aetna.com	(973) 244-3539	2:00 PM	
Board Liaison: Jill Squiers – Jill.Squiers@AmeriHealth.com	(609) 662-2533	WebEx	
Physician Practice Issues Forum			
Chair: Michael McLafferty – michael@mjmaes.com	(732) 598-8858	Third Wednesday of the Month	Webex
Board Liaison: Erica Waller – erica.waller@pennmedicine.upenn.edu	(609) 620-8335	8:00AM In person with call in available	In person Meetings
		WebEx: https://mjmadvisoryandeducationalservicesllc.my.webex.com/meet/michael	by Notification
Regulatory & Reimbursement			
Chair: Jason Friedman – Jason.friedman@atlantichealth.org	(973) 656-6951	Third Tuesday of each month	Conference Call (712) 770-5354
Co-Chair: Chris Czvornyek – chris@hospitalalliance.org	(609) 989-8200	9:00 AM	In Person Meetings
Co-Chair: Christine Gordon – cgordon@virtua.org	(856) 355-0655	Access Code: 382856	by Notification
Board Liaison: Scott Besler – scott.besler@toyonassociates.com	(888) 514-9312		
Revenue Integrity			
Chair: Tiffani Bouchard – tbouchard@panaceainc.com	(651) 272-0587	Second Wednesday of each month	Conference Call (712) 770-5021
Co-Chair: Jennifer Daniels – jdaniels@panaceainc.com	(651) 424-4233	9:00 AM	In Person Meetings
Board Liaison: Jonathan Besler – jbesler@besler.com	(732) 392-8238	Access Code: 419677	by Notification
CPE Designation			
Chair: Lew Bivona – lewcpa@gmail.com	(609) 254-8141		
CLE Designation			
Chair: Michael P. McKeever, CPA – m.mckeever2@verizon.net	(609) 731-4528		

Federal "No Surprises Act" Brings National Oversight of Unexpected Billing for Healthcare Services

Neil M. Sullivan

Christopher D. Adams

by Neil M. Sullivan, Esq. and Christopher D. Adams, Esq.

In the waning days of Donald Trump's administration, the federal government passed the "No Surprises Act," which becomes effective January 1, 2022. Like many recent state laws, the legislation is aimed at protecting patients from unexpected balances owed to healthcare providers outside of their network plans, particularly when there was no advance notice of the potential bills, as would often occur with respect to emergency services, or services from hospital-based providers when those providers are not in the patient's insurance plan network. The legislation seeks to remove patients from the middle of out-of-network reimbursement disputes.

Overview of Federal and NJ/NY State Laws

The reach of state laws addressing these issues has been limited, largely due to three reasons:

1. State laws relating to employee benefit plans that are not insured are preempted by the Federal Employee Retirement Income Security Act (ERISA);
2. Federal laws governing some government programs, such as Medicare Advantage and the Federal Employees Health Benefits Plan covering federal employees, also preempt many state insurance laws; and
3. State insurance laws are generally limited to insurance policies issued in that state, so a New York resident insured under an employer's Pennsylvania group policy may not fall under the protection of New York law.

Federal law can theoretically reach all of these circumstances however the No Surprises Act defers to state laws to the extent they apply to payment amounts. As such, the foreseeable future will be defined by a crazy quilt of state and federal requirements.

The No Surprises Act was included as part of the Consolidated Appropriations Act, 2021 that became effective on December 27, 2020 however most sections of the law do not go into effect until January 1, 2022. The Centers for Medicare & Medicaid Services (CMS) is charged with promulgating regulations, which are expected shortly.

New Jersey's Out-of-Network Consumer Protection, Transparency, Cost Containment, and Accountability Act became effective on August 30, 2018. Similar to New York State Public Health Law (PHL) §24, effective March 31, 2015, it requires healthcare payers and providers to make certain disclosures to patients and prospective patients regarding out-of-network providers and imposes limits on the ability of payers and providers to balance bill patients.

The federal law and many state laws, including those of New York and New Jersey, have the following basic tenets in common:

- Patients must be held harmless from unanticipated costs of medical treatment beyond the in-network cost-sharing responsibilities (deductibles, coinsurance and co-payments) under their health plans;
- Health plans and providers must make pricing and network status available; and

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- A dispute resolution process is established for payment disputes between plans and providers.

A threshold issue under all is whether the bill is a 'surprise' – unknowable in advance of receipt of services like emergency care or some other hospital-based services. Different rules apply to bills that should not be a surprise – those known and consented to in advance of the receipt of services including elective procedures.

The federal, New Jersey and New York laws track closely with what is considered to be a surprise, and in keeping patients out of the middle of balance billing disputes. The No Surprises Act anticipates regulations that will be much more prescriptive than either New Jersey or New York in terms of consents that would be required. It defers to existing state laws with respect to state-established payment amounts. For states like New Jersey and New York with rules for surprise medical billing disputes, the state's dispute resolution mechanism continues to govern disputes between insurers and out-of-network providers in that state for the fully insured plans they are able to regulate. The federal dispute resolution mechanism would reach those bills not subject to state law.

Major Provisions of the Federal Law & Summary Comparison to NJ/NY State Laws (Focus on Healthcare Providers Application)

Balance Billing

Under all three laws, balance billing as we know it will be prohibited for surprise bills. Patients unexpectedly receiving medical services from a provider out-of-network with the patient's health benefit plan will be required to pay no more than if the provider had been in-network with the patient's plan. Additional amounts sought must be worked out between the provider and payer, up to and including independent dispute resolution mechanisms as described below.

Transparency Regarding Non-Network Services

A. Federal Transparency Requirements

Cost transparency is an area where the No Surprises Law is significantly more prescriptive than the New Jersey and New York laws. The Health & Human Services (HHS) Secretary must issue further guidance on these requirements by July 1, 2021, including specifying the form to document patient consent.

Health plans are required to provide their members with an "advanced explanation of benefits" before an elective procedure, disclosing the provider's network status and a good faith estimate of the member's cost-sharing obligations. A good faith estimate of costs and cost-sharing by the health plan must identify whether the provider(s) furnishing the items or services is in-network and, if not, how to locate in-network providers. Insurers will also have to offer price comparison information by phone, develop a web-based price comparison tool, and maintain up-to-date provider directories.

Providers must make efforts to obtain the patient's enrollment status and provide "good faith estimates" of the total expected charges for scheduled items or services. This includes any expected ancillary services. The notice must also include the expected billing and diagnostic codes for all items and services to be provided. This requirement will apply whenever items or services are scheduled at least three days in advance or when requested by a patient. The provider will need to determine the patient's health coverage status and develop the "good faith estimate" at least three business days before the service is furnished and no later than one business day after scheduling, unless the service is scheduled for more than 10 business days later. In those instances, the provider will need to furnish the information within three business days of a patient requesting an estimate or scheduling a service.

For providers who are eligible to ask a patient for a consent waiver, the provider must generally notify the patient in writing 72 hours before services are scheduled to be delivered. This notification must include a good faith cost estimate and identify available in-network options for obtaining the service. The notice must contain at least the following information: notification that the provider is out-of-network; a good faith estimate of the charges; a list of in-network providers at the facility (if the facility is in-network) to which the patient can be referred; information on any prior authorization or other care management requirements; and a clear statement that consent is optional and that the patient can instead opt for an in-network provider. The HHS Secretary must issue further guidance on these requirements by July 1, 2021, including specifying the form to document patient consent.

An out-of-network provider can balance bill a patient for elective items or services if they satisfy the notice and consent requirements of the law. The notice and consent process cannot be used for certain services, including certain ancillary services, and items or services that are delivered as a result of an unforeseen urgent medical need that arises during a procedure for which notice and consent was received.

Ancillary Services for Which Notice and Consent Option Does Not Apply.

Patients receiving the following nonemergency ancillary services may not be billed beyond their in-network cost-sharing amount without regard to the existence of a signed consent:

- Items and services related to emergency medicine, including anesthesiology, pathology, radiology, neonatology, diagnostic services (including radiology and laboratory services);

- If there is no in-network provider available to furnish the item or service at the facility.

Provider Disclosure of Balance Billing Protections.

All healthcare providers must make information on patients' rights with respect to balance billing publicly available. This notice should also be available on the providers' public websites. The notice must contain information on the requirements established under the law, information on any state-level protections if applicable, and contact information for state and federal agencies to report any potential violations.

The legislation also allows certain providers to request that a patient sign a consent waiver. But this exception is relatively narrow and generally more protective of consumers than state laws that allow for consent waivers. This exception is only allowed in nonemergency situations.

B. New York Transparency Requirements

The New York state law includes separate disclosure requirements for hospitals and other healthcare providers. While the requirements are different and detailed, they are generally intended to impart network status, identification of affiliated providers, and either pricing information or a method to obtain pricing information.

The New York law also requires consents for elective services. The law refers to "explicit written consent of the insured acknowledging that the participating physician is referring the insured to a non-participating provider and that the referral may result in costs not covered by the health care plan..." Presumably, similar language would apply to services in a participating facility. To preserve its right to pursue a balance from the payer, non-participating providers billing a patient for emergency services should include an assignment of benefits (AOB) form and a claim form for a third-party payor with the patient's bill.

If there is advance consent as described above prior to the provision of non-emergency services, the limits on balance billing the patients would not apply. Aside from the consent requirement, disclosure requirements apply. Absent the required consent and disclosure, the bill would be considered a 'Surprise Bill' and subject to the limits on the ability to balance bill.

C. New Jersey Transparency Requirements

The transparency provisions of the New Jersey state law apply to all carriers operating in New Jersey with regards to health benefits plans that are issued in New Jersey. Carriers are required to:

- Maintain up-to-date website postings of network providers;
- Provide clear and detailed information regarding how voluntary out-of-network services are covered for plans that feature out-of-network coverage;
- Provide examples of out-of-network costs;
- Provide treatment-specific information as to estimated costs when requested by a covered person; and
- Maintain a telephone hotline to address questions.

Dispute Resolution

A. Federal Arbitration Process

Under the No Surprises Act, insurers and providers have 30 days to negotiate payment disputes. If negotiations fail, either party may, within four days, request independent dispute resolution.

The arbitration process will be administered by independent dispute resolution entities subject to conflict-of-interest standards. The federal government will establish the independent dispute resolution process, including a list of entities available to take cases.

Like the New Jersey law, the No Surprises Act adopts "baseball-style" arbitration rules: each party offers a payment amount, and the arbitrator selects one amount or the other with no ability to split the difference. The decision is then binding on the parties, although the parties can continue to negotiate or settle. Multiple cases involving the same provider, payer, treatment of the same or similar medical condition, that have occurred within a single 30-day period can be combined in a single arbitration proceeding.

The losing party will be responsible for paying the administrative costs of arbitration.

Arbitration Factors.

Arbitrators can consider a range of factors, including any relevant factors raised by the parties, but not the provider's usual and customary charge or the billed charge. Optional factors that an arbitrator can consider include the level of training or experience of the provider or facility; the quality and outcomes measurements of the provider or facility; market share held by the out-of-network healthcare provider or facility, or by the plan or issuer in the geographic region in which the item or service was provided; patient acuity and complexity of services provided; teaching status, case mix, and scope of services of the facility; any good faith effort—or lack thereof—to join the insurer's network; and any prior contracted rates over the previous four years. Arbitrators would also be able to consider the median in-network rate paid by the insurer.

B. New Jersey Arbitration Process

New Jersey has contracted with MAXIMUS, Inc. to administer its Out-of-Network Arbitration System. Like the New York law, New Jersey's law is limited to fully insured payer

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contracts. However, self-funded plans may be subject to the claims processing and arbitration provisions and be subject to the same arbitration process as carriers in the insured markets.

An out-of-network provider has 30 days to contact the carrier to negotiate a final reimbursement amount if the provider does not accept the carrier's determination as payment in full. If a settlement is reached, the carrier must remit the additional payment to the out-of-network provider within 30 days. If no settlement is reached in that 30-day negotiation period, the carrier must pay its final offered reimbursement amount to the out-of-network provider within 7 days, assuming the carrier offered an amount higher than its initial allowed charge.

After that, either party may submit a request for a binding "baseball-style" arbitration to MAXIMUS, the New Jersey Department of Bank and Insurance's (DOBI) out-of-network arbitration vendor, provided that (i) the difference between the carrier's final offer and the provider's final offer is equal to or greater than $1,000, and (ii) the matter does not involve a dispute regarding the characterization of services. Arbitration does not apply in situations where a patient knowingly, voluntarily, and specifically selected an out-of-network provider.

A self-funded plan may opt to be subject to the claims processing and arbitration provisions and to be subject to the same arbitration process as carriers in the insured markets.

Fears of arbitration should not worry providers too much. A study published in the January 2021 edition of *Health Affairs* analyzed 1,695 surprise billing arbitration cases that were filed and completed in New Jersey in 2019. The study found that the median decision resulted in awards 5.7 times the prevailing in-network rates for the same services. The four most common specialties that participated in arbitrations in New Jersey were orthopedics, general surgery, plastic surgery, and trauma and emergency medicine.

C. New York Alternate Dispute Resolution

If a patient signs an AOB form for an emergency service, or for a "Surprise Bill' as defined above, the physician cannot balance bill the patient beyond their in-network cost-sharing. The payer, however, is required to pay the non-participating provider the billed amount or attempt to negotiate reimbursement. If the patient was sent, but did not sign, the AOB, the non-participating physician can bill the patient, who will be responsible for disputing any amount unpaid by the insurer.

If the physician and payer cannot resolve the appropriate payment amount pursuant to the AOB, the payer is required to pay an amount that is 'reasonable.'

An independent dispute resolution program has been established by New York to dispute the payer's determination of what is reasonable, with some exceptions. Providers would make application for dispute resolution through the New York Division of Financial Services, which will assign the matter to an Independent Dispute Resolution Entity.

Penalty Provisions

With respect to providers, the No Surprises Act allows states to require a provider to comply with the new standards and contains enforcement provisions similar to those under the Affordable Care Act and HIPAA. That is, states will continue to regulate fully insured group medical plans and the Department of Labor will regulate self-insured plans. The federal enforcement provisions provide for civil monetary penalties up to $10,000 per violation and the creation of a federal process to receive consumer complaints related to surprise medical bills.

Conclusion

Providers caring for patients outside of the patient's health plan network should educate themselves in the requirements that presently and in the future will impact the amount and ability to get paid for their services. Requirements impacting balance billing, transparency, and alternate dispute resolution continue to evolve, and an added level of federal requirements promises to continue to change the landscape into the foreseeable future.

About the Authors

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The New Jersey Economic Recovery Act of 2020: An Overview of the New Jersey Community-Anchored Development Program

Steven G. Mlenak

James A. Robertson

by Steven G. Mlenak, Esq. and James A. Robertson, Esq.

The New Jersey Economic Recovery Act of 2020, a seven-year, $14 billion package of incentive programs intended to encourage New Jersey job growth, property development and redevelopment, community partnerships, and numerous other economic development initiatives, was signed into law by Governor Phil Murphy on January 7, 2021.

This article focuses on the New Jersey Community-Anchored Development Program, which was enacted under the new legislation to provide tax credits to "anchor institutions" to encourage the expansion of targeted industries in certain areas of New Jersey.

Incentivizing Anchor Institutions

The New Jersey Community-Anchored Development Program aims to incentivize anchor institutions in the areas of education, healthcare, culture, community development, and economic development to act as investors in large-scale development projects within New Jersey. Under the program, an anchor institution will utilize proceeds from the sale of state tax credits, and the New Jersey Economic Development Authority (EDA) will receive a negotiated current or deferred economic return on the tax credit investment made by the anchor institution and, ultimately, the return of the amount initially received.

Anchor institutions will be eligible for tax credits of up to $200 million annually to aid and promote targeted development, with $130 million allocated to northern NJ counties and $70 million to southern NJ counties. The total tax credit allowed per project cannot exceed $75 million, and the total investment of all state resources in a project (not including rent payments) cannot exceed 40% of the total cost of the project.

The goal of the program is to overcome cost-of-occupancy differences between New Jersey and other less expensive jurisdictions, and to encourage anchor institutions to expand beyond their host communities and invest in areas that lack anchor institutions. Additionally, the legislation hopes to further New Jersey's objectives to attract high-value employers and provide economic stimulus, as well as permit other beneficial uses such as housing, public amenities, parking, mixed-uses, and facilities of an anchor institution itself.

Application Criteria

To take advantage of the Community-Anchored Development Program, anchor institutions must complete and submit to the EDA a competitive program application that would result in the completion of a community-anchored project either in a New Jersey opportunity zone or, if the project is primarily designed to result in the economic expansion of a targeted industry, in an area designated as a Planning Area I, or in a municipality with a Municipal Revitalization Index distress score of at least 50.

When making its application, the anchor institution must demonstrate the following:

1. The structure and terms of the investments to be utilized to successfully complete and then operate the project;
2. That the anchor institution has not commenced any construction at the site of the project prior to submit-

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ting the application, unless the EDA determines the project would not be completed otherwise or if the requested tax credit converts only phases of construction which had not yet commenced;

3. The value of the tax credit that is necessary in each year of the eligibility period;
4. The total aggregate value of the tax credit for the entire eligibility period that is necessary;
5. The award of tax credits under the program that will be converted into an investment by the EDA into the project, and the anticipated current and deferred returns on that investment;
6. That the project will comply with the standards established by the EDA through regulation based on the green building manual;
7. That the project will comply with the EDA's affirmative action requirements;
8. A description of the significant economic, social, planning, employment, environmental, fiscal, and other benefits that would accrue to the state, county, or municipality;
9. That the anchor institution will partner with one or more local community organizations that provide support and services to Work First New Jersey program recipients;
10. The extent to which the development will result in the expansion of a targeted industry in New Jersey;
11. That the timing of the award and investment of tax credits under the program will allow for the successful completion and operation of the project; and
12. That the project is viable, and that the anchor institution is a credible partner.

The project must result in a capital investment of at least $10 million. The anchor institution receiving tax credits must then use the proceeds derived from the sale or financing of the tax credits to make an equity investment in, or provide a loan or other financial support for, the community-anchored project.

The tax credits will be issued and utilized according to an agreement which includes standards relating to the anticipated economic results of the anchor institution's project as well as consequences for failing to meet the requirements of the agreement. The tax credit agreement will detail the terms by which the anchor institution will convert the tax credits into an investment.

The tax credits may be sold or transferred by the anchor institution or, alternatively, the credits may be used to finance the completion of the project. The sale proceeds must then be used to make an equity investment in or to provide a loan or other financial support for a community-anchored project. This is particularly important given many anchor institutions are nonprofit corporations that would be otherwise unable to utilize such credits.

Scoring System for Approval

The EDA's approval process will review and rank applications on the basis of a scoring system based on criteria which includes but is not limited to:

1. The amount of tax credit requested compared to the overall investments required for completion, along with the amount of the potential return on the EDA's investment;
2. The financial benefit of the project to the community where it will be located;
3. Apprenticeships or workforce programs to be offered because of the project;
4. The ability of the project to absorb and adapt to changing environmental conditions;
5. How the project will advance state, regional, and local development and planning strategies;
6. The relationship of the project to a comprehensive local development strategy;
7. The degree to which the project enhances and promotes job creation and economic development;
8. The extent of economic and related social distress in the area surrounding the project;
9. The extent to which the project provides for the development of workforce housing and housing for individuals with special needs;
10. The extent to which the project constitutes the expansion of the institution to different areas of the state;
11. The extent to which the project provides for infrastructure, parking, retail, green space, or other public amenities creating a mixed-use project;
12. The inclusion of a qualified business accelerator or incubator facility as part of the project;
13. The length of the commitment period for the project;
14. The quality and number of new full-time jobs that will be created by the anchor institution;
15. The quality and number of existing full-time jobs that will be retained by the anchor institution; and
16. The extent to which the board of directors of the anchor institution is diverse and representative of the community in which the project is located.

The EDA will continue to evaluate the program to ensure that it will, at least, recapture the value of the tax credits awarded to all anchor institutions and will realize additional returns on investment under the program.

Comprehensive regulations are expected to be promulgated by the EDA in furtherance of the New Jersey Community-Anchored Development Program. We will keep you updated on these rules and other developments related to the New Jersey Economic Recovery Act of 2020.

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•Focus on...New Jobs in New Jersey•

JOB BANK SUMMARY LISTING

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

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

Job Position and Organization

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Tri Boro Physical Therapy

ACCOUNTANT
Capital Health, Lawrenceville, NJ

FINANCE OPERATIONS ANALYST
CentraState Healthcare System

APPEALS & DENIAL COORDINATOR RN
CentraState Healthcare System

FINANCIAL ANALYST
Valley Health System

DECISION SUPPORT COORDINATOR
Valley Health System

REVENUE INTEGRITY ANALYST
Valley Health System

TAX MANAGER/TAX SENIOR
Withum

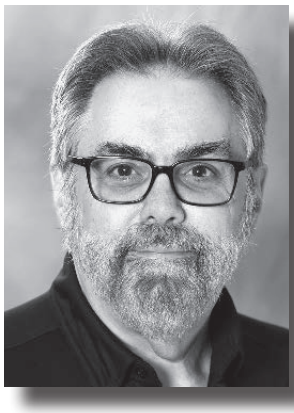
AUDIT MANAGER/AUDIT SENIOR
Withum

MANAGER OF BUDGET & REIMBURSEMENT
CentraState Healthcare System

MANAGER OF MANAGED CARE
CentraState Healthcare System

Cooking Along With NJ HFMA

by Michael P. McKeever



Michael P. McKeever

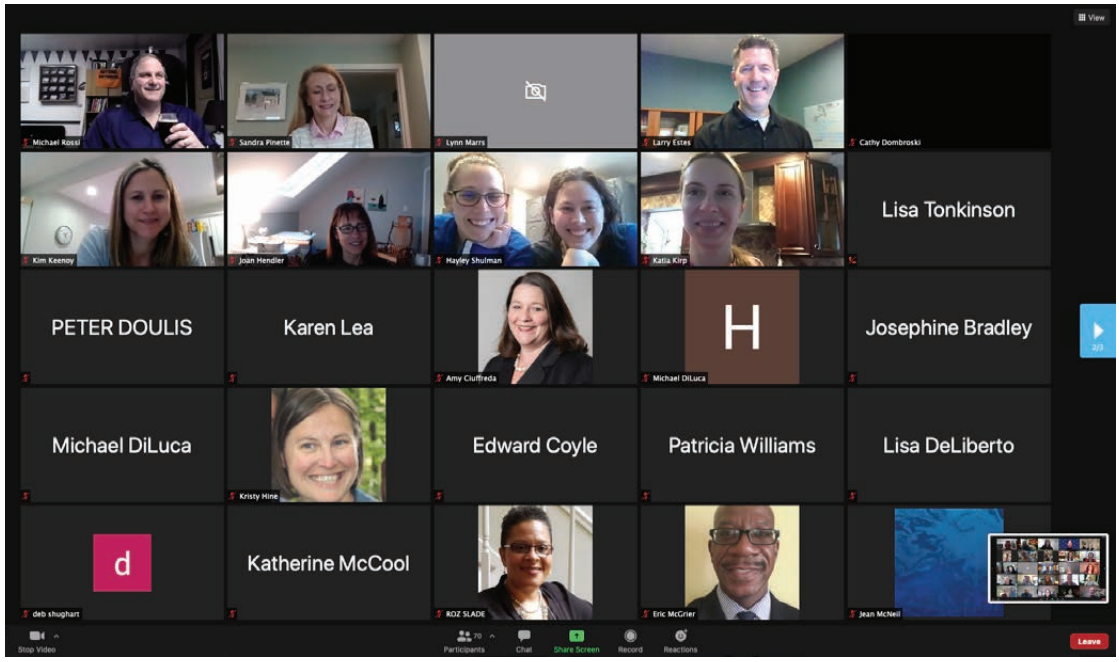
Since the beginning of the pandemic organizations have had to adapt to a new reality where we could no longer meet face to face and out of necessity went virtual. The New Jersey Chapter continues to feel these constraints, but has also developed engaging programs providing both educational and networking opportunities for the members. At the forefront of this effort has been the Membership Services and Networking Committee, Chaired by Nicole Rosen along with Co-Chair John Byrne and Board Liaison Heather Stanisci. In the beginning the committee hosted typical Zoom networking events, where participants had the opportunity to interact with old friends and meet new ones. As we all became more familiar with Zoom, breakout rooms were added that enabled more focused discussions. But thinking way out of the box, they've hosted some pretty interesting events, including a magic show and an educational session on wine, presented by one of the few female sommeliers. Recently they hosted an event that few who participated in will soon forget.

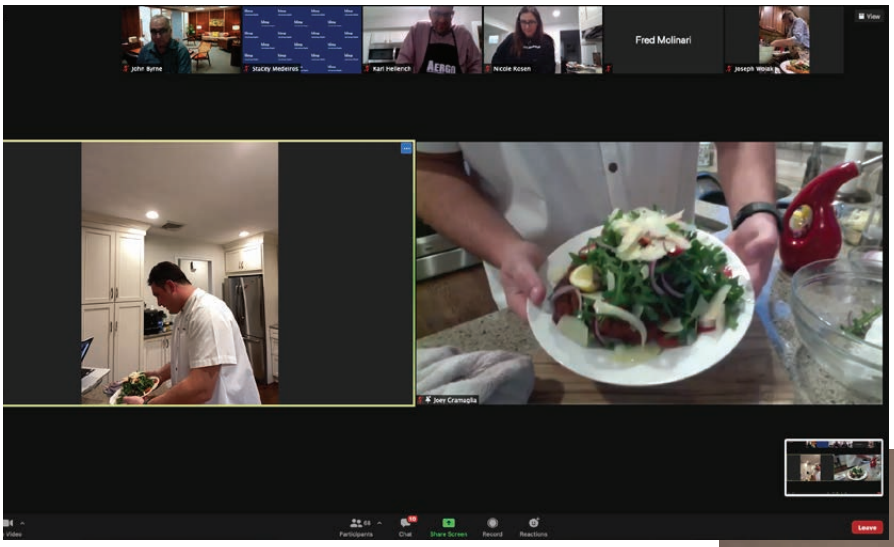
On the afternoon of March 24 Joseph "Joey" Gramaglia, winner of the Food Network's Chopped Award and Executive Chef/Owner of Sally G's Restaurant and Tavern in Warren NJ welcomed attendees into his home kitchen and walked us through the steps for making as an appetizer Shrimp Oreganata and for our entrée Chicken Milanese. Recognizing that this session would have broad appeal, it was decided to promote the event to all the Chapters in Region 3, which we've done in the past with our more elaborate networking sessions. And a special thanks to Aergo Solutions, who sponsored the event.

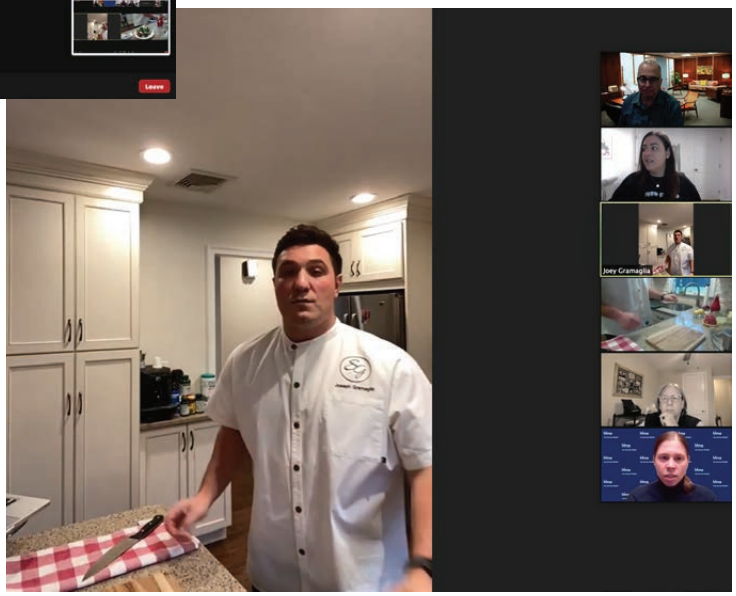
Attendees were sent a list of ingredients prior to the event so that they could follow along, preparing the dishes in their own kitchens. So rather than seeing attendees staring at their computers and phones we saw them hard at work preparing a dinner that they could enjoy with their families. The interactive chat function allowed attendees to ask questions in real time, so that they could successfully participate in the virtual cooking demonstration. Afterwards a number of participants posted pictures of themselves cooking, along with pictures of the finished dishes, on social media. Hard to believe that anyone who joined the event or saw pictures of the finished product wasn't left a little hungry.

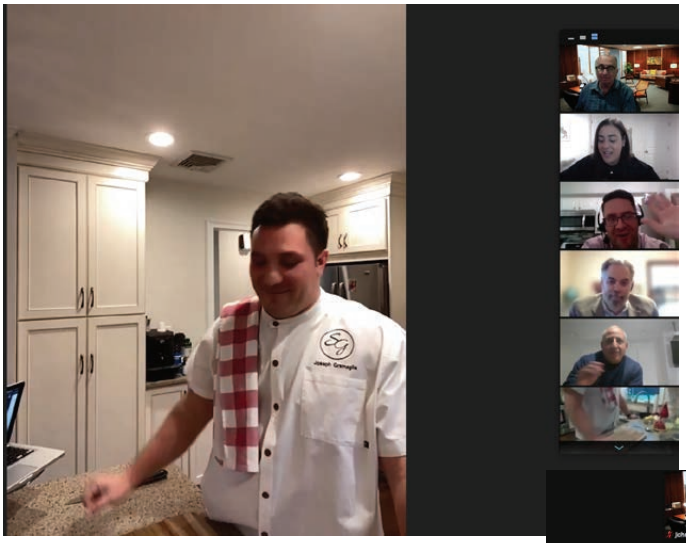
Along with the interactive discussion in the chat was immediate and positive feedback for the session and the NJ HFMA team responsible for the event. More than one attendee judged this the best interactive networking event ever. Others asked that we bring Joey back to share more of his recipes and techniques in future webinars. Members commented on Joey's habit of washing his utensils as he went along, so that his kitchen remained clean and ready for the next dish. And everyone commented on how delicious the dishes looked, and those who cooked along on how great everything tasted. In the future the committee is planning a session focused on overcoming the personal anxiety caused by the pandemic, as well as an educational session with a mixologist. At some point in the future we'll be able to gather in person again to share refreshments and enjoy each other's company, but in the meantime the Membership Services and Networking Committee has continued to bring value to the Chapter and our friends and families through these unique and creative events.

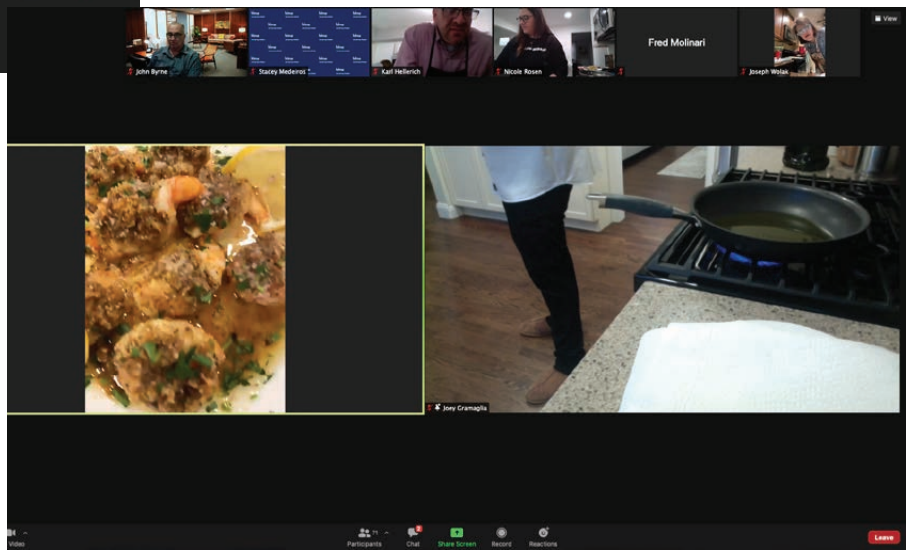
AERGO SOLUTIONS




Fred Molinari
Joey Gramaglia



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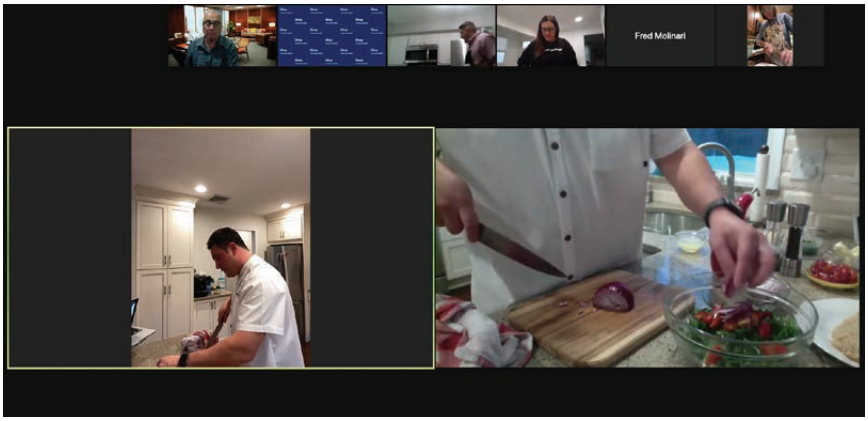

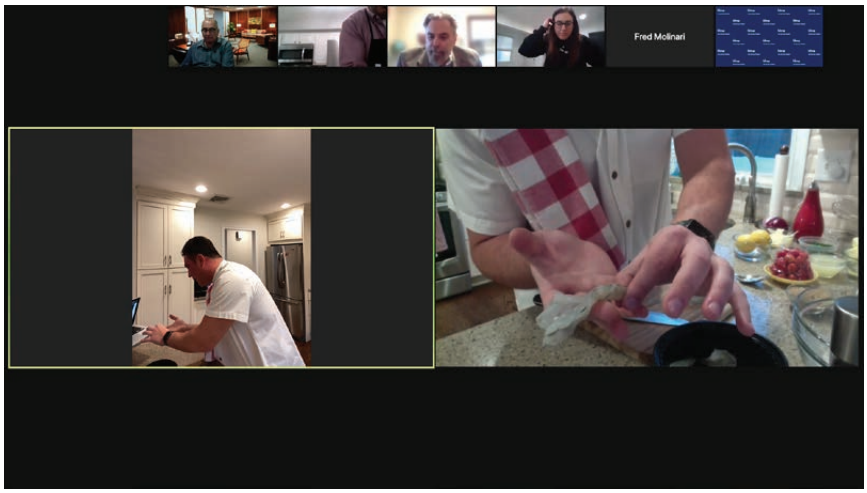

Golf Outing, circa 2010

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