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new jersey chapter

Winter 2021 • vol 68 • num 2

garden state focus

national excellence award winner

- 45th Annual Institute Draws a Bolder, Brighter, Better Crowd!
- 2021: Pandemic Year Two – How Did the U.S. Do?
- Top items to consider when preparing your Medicare Cost Report

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

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Who's Who in the Chapter 2021-2022

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Hayley Shulman..... WithumSmith + Brown, P.C.

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

DEADLINE FOR SUBMISSION OF MATERIAL

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

IDENTIFICATION STATEMENT

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OBJECTIVE

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

EDITORIAL POLICY

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

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

REPRINT POLICY

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The President's View . . .

Jill Squiers

Welcome to the Winter Edition of the *Garden State FOCUS*. As President of the New Jersey HFMA Chapter, and midway through my term that expires at the end of May, I've spent some time reflecting on where we've been as a Chapter, and what remains before us.

It's sometimes challenging to keep spirits up during the winter months with shorter daylight hours, and that's especially true as we enter the third year of the COVID-19 pandemic. As the number of cases waxes and wanes, the Chapter has responded by adjusting our approach to hosting education and networking events, which we anticipated could be the case when we slowly returned to in-person activities last Spring. As we take two steps forward, followed by one step back, I'm reminded that the volunteer leaders of the NJHFMA Chapter are among the most dedicated and resourceful individuals I've had the pleasure of working with.

As of this writing, the annual education session hosted jointly by the Patient Financial Services and Patient Access Services committees has been postponed until it's wise to meet again in person. The committees pivoted and instead offered a virtual (and timely) panel discussion addressing the federal No Surprises Act and its intersection with New Jersey's out of network law. And in the spirit of keeping up spirits, the Membership & Networking Committee announced a virtual Mixology event on February 10 that will guide participants in constructing craft cocktails from their home kitchens and bars. We plan to rejoin in-person activities starting with our popular Women's Leadership Conference on April 27, and our annual Golf Outing on May 12, returning to Mercer Oaks in West Windsor. During this time of uncertainty, I'm proud to say the Chapter hasn't missed a beat in responding to the education and networking needs of our members.

Which brings me to a celebration of the successful return of our Annual Institute last October. The event, hosted in collaboration with the Metropolitan Philadelphia Chapter, saw approximately 75 percent of our usual attendees returning for the three-day conference, which included 17 continuing education credits as well as unique networking events that recognized the need to gather safely. Our Wednesday night Charity Event – which included for the first time a 50/50 raffle in addition to the sponsor-donated tricky-tray prizes – generated more than six thousand dollars for the NJ Sharing Network, which coordinates the donation of life-saving organs and tissue for individuals in the state.

Please keep your eye on hfmanj.org for more information about our upcoming events! And if you'd like to join the ranks of our fantastic committee leadership – or ease into it as a contributing member – please reach out to me or one of the many Chapter leaders for more information. We are well on our way to meeting the challenge of being Bolder, Brighter, Better this year.

Jill A. Squiers

From The Editor . . .

Scott Besler

As we each find ways to enjoy the winter, a winter that has had some days that were colder than in years past, we are beginning to understand why so many move to Florida. We are grateful to the chapter members and their support through this time. We are approaching two years of the pandemic that has impacted our lives personally and professionally. We are eagerly awaiting when we can resume in-person meetings and thank you for your continued support AND patience. There is hope that that time will arrive sooner than later. We thank the efforts of Chapter President Jill Squires, who is doing all that she can to get us back to face-to-face events (even if it is mask -to-mask). We thank Jill, as well other executive board members, for their leadership and guidance.

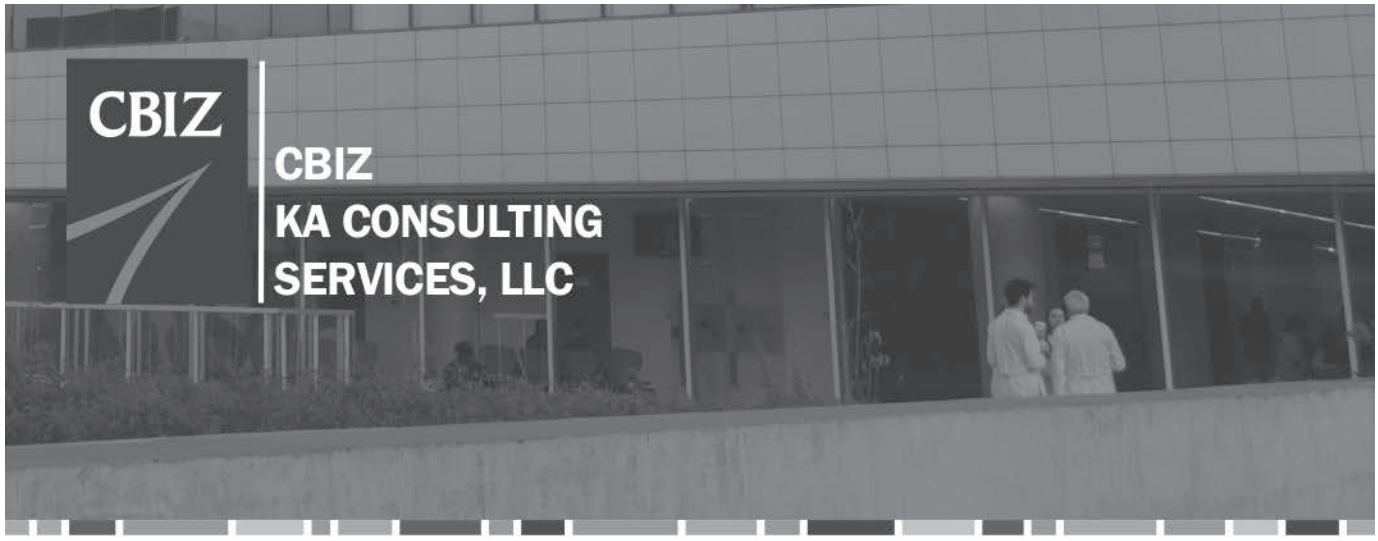
As you find that warm spot in your home (or on a beach) to peruse this edition, please take a look at John Dalton's summary of the 45th Annual Institute and realize how important it was for us a chapter to hold this event. Hats (but not masks) off to the planners as well as the attendees that followed the rules so that the event could be a success. Congratulations to those that received Chapter Awards, especially Nicole Rosen and John Byrne for receiving the President's Award. John also gives us our report care for Year Two of the PHE.

Included in this edition, is Lorrie Wood's article on Coordination of Benefits (COB) denials. Communication and timing are extremely important as hospitals and their revenue cycle teams must continue to work with patients and their insurance companies to improve the collection process. CFOs do not like leaving "money on the table" when it comes to these claims that are owed to the hospital. Johanna Orellana and John Smith, part of Withum's Healthcare Services Team discuss new requirements that stem from the Patient Protection and Affordable Care Act which a tax-exempt hospital systems must meet.

James Robertson and Steven Mlenak, author an overview of the New Jersey Emerge Program. This program was enacted as part of the Economic Recovery Act to provide tax credit incentives that will assist in job creation and also retention. There is also a summary of the OPPS and ASC final rule from a long standing friend of many chapters in the country, Larry Goldberg, senior advisor for Third Party Reimbursement. Toni Pergolin, our future keynote speaker at the Women's Educational Event (4/27/22) discusses the critical role that non-profit organizations play in providing care and touches on "margin vs. mission" and how mission is just as important in the long-term.

We thank the folks at Moss Adams for their articles, Mandy Mori and Denise Stark, who discuss COVID-19 recoupments and Mike Newell, who discusses the proper submission and strict rules surrounding amending cost reports. We also are grateful to Josh Weissenborn and Andrew Kinnaman from BESLER that highlight a checklist to review as many 12/31 year-ends begin their cost reporting season. The arrival of Transmittal 17 and soon-to-be Transmittal 18 will also provide needed guidance for all cost report preparers.

We at the *FOCUS* committee and chapter leaders hope you ride out the rest of winter both healthy and happy as we look forward to seeing you at chapter events. Thank you.



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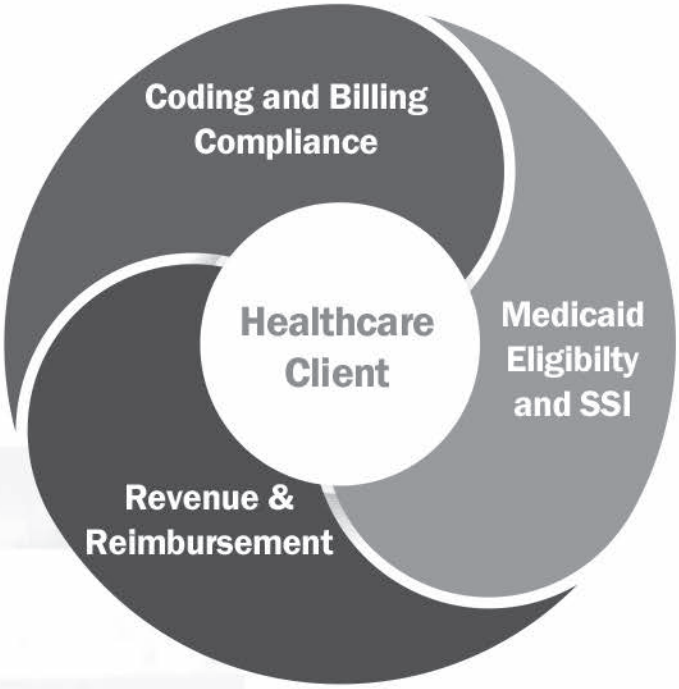

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45th Annual Institute Draws a Bolder, Brighter, Better Crowd!

John Dalton

by John Dalton, FHFMA

Perhaps it was the longing to see colleagues in the flesh for the first time in 18 months.

Perhaps it was the need to garner CPEs needed to maintain certification.

Perhaps it was just the need to get away for a couple of days from the grind of coping with Covid.

Whatever the reason, more than 340 people from the New Jersey and Metropolitan Philadelphia HFMA Chapters registered for the 45th NJHFMA Annual Institute held once again at the Borgata Hotel Casino and Spa in Atlantic City October 6-8 for 2-1/2 days of educational sessions providing up to 17 CPEs. With the safety of attendees at the Annual Institute a top priority, registrants were required to:

- Provide proof of vaccination or a negative COVID-19 test within 5 days of arrival to the event.
- Wear a mask for the duration of the conference except while eating or drinking or socially distanced from others.
- Leave the conference if they felt ill or began to exhibit symptoms and contact hfma@dlplan.com so we can contact other attendees.

The precautions paid off and the smiles beneath the masks were bolder, brighter and better as they greeted colleagues in person. Institute Chair Maria Facciponti, Co-Chairs Brian Herdman and Stacey Medeiros, "Casting Director" Sandy Gubbine and their hard-working Committee organized a dynamic menu that contained seven general sessions and 28 breakout sessions on varied topics including Finance, Compliance, Data, Revenue Cycle, and Payer Issues. Wednesday night's charity event once again benefitted the New Jersey Sharing Network.

The Institute opened with a working lunch at noon on Wednesday. Chapter President Jill Squiers welcomed attendees, reviewed the schedule for the Institute and thanked the many sponsors without whose support a cost-effective educational institute would not be possible. She then turned the podium over to John Dalton, serving once again as Master of Ceremonies, to introduce the first speaker.

Attacking MA Denials

Day Egusguiza traveled from pandemic-plagued Idaho to open the Institute with guidance on attacking Medicare Advantage (MA) denials. With one of the country's lowest vaccination rates, the state's ICUs were overflowing with unvaccinated Covid cases, elective surgeries had been canceled and crisis standards of care had been implemented. Relieved to be in a safer venue, Day provided attendees with illuminating insights into dealing with MA denials. There now are about 4,800 MA plans covering 40% of Medicare enrollees, an average of 47 plans per county. Most plans collapse Parts A, B and D into a single monthly premium that usually is lower than Traditional Medicare while offering additional benefits including some dental, hearing and vision coverage. Each MA plan has a separate contract with CMS.

Unlike Traditional Medicare, each MA plan sets its own rules, so payer definitions differ, creating immense complexities for hospitals dealing with multiple plans. Ms. Egusguiza recommends that, at a minimum, providers set up a Payer-Specific Matrix to help in dealing with the varying criteria used by MA plans. The presentation included several detailed examples of tactics to be used in contesting MA denials.

After the Vendor Hall was opened to attendees, a series of three afternoon breakout sessions afforded attendees the choice among twelve topics.

Chapter Awards

Thursday morning opened with current Chapter President Jill Squiers and Immediate Past President Stacey Medeiros presenting the Chapter Awards for the fiscal year ended May 31, 2021. Stacey Medeiros began by presenting the 2021 President's Award to Nicole Rosen and John Byrne for leading Membership and Networking efforts during a very difficult chapter year where members were unable to gather in person due to the Covid-19 pandemic. She noted that our members truly appreciated the innovative, creative events that Nicole and John worked diligently to provide.

The Outstanding Member in a Non-Leadership Position Award recognizes a member who works behind the scenes in creating a successful chapter and distinguishes themselves by continually going "beyond the call of duty." Maria Lopes-Tyburczy was recognized for her many years of work with the Patient Access Committee.

The Founders Medal of Honor Award is the highest honor that a Chapter can bestow on a member. It is awarded based on volunteer activities within HFMA over time and voted on by the board of the New Jersey chapter of HFMA. B. J. Welch is the 2020–21 Medal of Honor winner in recognition of her commitment to the chapter over the past many years.

Next up, attendees learned *"What to Expect Now That Cannabis is Legal"* from two attorneys and a social worker who have been deeply involved in the issue:

- Sarah Trent, founder of Valley Wellness and Secretary of the New Jersey Bar Association's Cannabis Law Committee;
- Dr. Jan Roberts, a licensed clinical social worker, educator and entrepreneur, founder of the Cannabinoid Institute; and
- Seth Tipton, partner at the law firm of Florio Perrucci Steinhardt Cappelli Tipton & Taylor, where he represents operators and applicants for permits.

The key takeaway from the session was an appreciation of the labyrinthine complexity of the process facing applicants for permits to legally sell cannabis-based products in New Jersey. Each state has its own set of rules and definitions, and they vary widely. Cannabis is not marijuana. Marijuana continues to be a Schedule 1 drug under the federal Controlled Substances Act of 1970, while cannabis has been descheduled in New Jersey.

They were followed by Bob Bacon's presentation of *"Hot Topics in Billing and Compliance."* Mr. Bacon is the Vice President and Billing Compliance Officer for Penn Medicine and a frequent speaker and writer on the subject. He covered the following topics:

- Government Audit Activity;
- Price Transparency;
- Telehealth;
- No Surprise Billing Act; and
- 2021 Revised E&M Guidelines.

Keynote Address

John Dalton and Ed Eichhorn, cofounders of the Healing American Healthcare Coalition, delivered the keynote address: *"The Covid-19 Pandemic: What have we learned and where do we go from here?"* When Metro New York joined Milan and Madrid as the global epicenters of the pandemic in March 2020, they launched the twice monthly Three Minute Read™ to provide busy healthcare professionals with brief summaries of articles of interest to them. The articles summarized fell into several distinct categories – the pandemic, whether global or in specific countries, universal healthcare, and provider, insurance and pharmaceutical issues.

Their presentation highlighted news in each of these categories over the past 20 months through the eyes of the journalists who reported on them, then concluded with some key lessons gleaned from the pandemic and as well as some thoughts on where America goes from here. The Covid-19 pandemic placed enormous pressure on America's healthcare system, exposing many weaknesses that need to be addressed before the next outbreak. They include:

- America must continue moving healthcare's emphasis from treating diseases to promoting health.
- Telehealth is here to stay.
- China is not America's friend.
- Offshoring the manufacture of critical elements in the supply chain led to critical shortages.
- Burnout among frontline clinicians is endemic. After the pandemic, who will care for us?
- Consistent commitment to protecting their residents is crucial to containing outbreaks, whether at federal, state or local levels. Letting politics trump public health is unacceptable.
- Longer term, America should emulate the Scandinavians, whose countries controlled Covid-19 better than most and consistently rank among the happiest people in the world in annual surveys.

Dalton and Eichhorn cover these issues in greater detail as coauthors of "*Healing American Healthcare – Lessons from the Pandemic"* released in December.

The lunch hour included three opportunities to "Lunch & Learn," followed by four afternoon breakout sessions on fourteen different topics.

President's Reception & Late Night

For those hearty souls who survived eight hours of continuing education, the President's Reception and Late Night provided some much-needed relaxation. The weather cooperated and the President's Reception was held outdoors in the Borgata's Beer Garden. The Speakeasy themed late-night event at the Premier Nightclub had a distinctive Roaring Twenties flavor that was a welcome distraction from this century's "Pandemic Twenties."

Rested and refreshed, attendees reconvened Friday morning for the Institute's final three general sessions. Sandra Lane, a Board-Certified Professional Organizer, challenged them to

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"Stop Procrastinating & Start Producing," noting that 95% of us procrastinate. She provided a road map to outsmart procrastination that included avoiding perfection paralysis, stating that "Done is better than none." Ms. Lane walked attendees through an exercise that clearly demonstrated the adverse effect of distractions on completing assigned tasks, then offered several helpful tips to beat the urge to delay and defer.

Wardell Sanders, President of the New Jersey Association of Health Plans (NJAHP), addressed *"Where the Health Care Dollar is Spent."* NJAHP is the state trade association that represents the major health plans in New Jersey, including all five Medicaid health plans. More than half of New Jersey residents receive their health insurance coverage through the commercial marketplace, but less than one-third of that marketplace is regulated by the Department of Banking and Insurance (DOBI). Most of the coverage is through self-funded plans that are not regulated by DOBI (see table, "NJ Source of Coverage 2020").

Mr. Sanders' presentation included AHIP's breakdown of where the premium dollar is spent. Hospital inpatient, outpatient and ED care account for 42.0%; prescription drugs, 21.5%; doctor visits, 12.1%; and Other Outpatient Care, 6.0% for a total of 81.6%. The rest of the premium dollar breaks down as follows: Taxes and fees, 4.6%; other fees and business expenses, 3.1%; cost containment 2.4%; quality improvement, 0.8%; other administrative expenses, 4.4%; and profit 3.0%. His presentation also included the varying ways that Medical Loss Ratios (MLRs) are calculated and the status of New Jersey's development of a cost growth benchmark as directed by Governor Murphy's Executive Order 217 to identify public and private sector opportunities to advance shared goals of improved health care affordability.

NJ Source of Coverage 2020 (created 4/20/21)	# of NJ Residents	% of NJ Residents
A. Commercial Markets Regulated by DOBI:		
Large employer (>50 employees)	637,847	7.18%
Small employer (1-50 employees)	300,197	3.38%
Self-Funded MEWAs	45,273	0.51%
Individual Market	310,650	3.50%
Student	27,000	0.30%
DOBI regulated total:	*1,320,967*	14.87%
B. Commercial Markets Not Regulated by DOBI:		
Self-funded plans (mostly large employers)	3,293,376	37.08%
Self-funded, level funded (mostly small employers)	69,633	0.78%
Commercial non-regulated total:	*3,363,009*	37.08%
C. Government Not Regulated by DOBI:		
Medicare (Medicare, Medicare Adv, includes duals)	1,634,896	18.41%
NJFC/Medicaid <65 (removes Medicare duals)	1,425,917	16.05%
Federal VA	96,000	1.08%
Tricare	87,028	0.98%
NJ SHBP/SEHBP non-Medicare	590,524	6.65%
FEHBP < 65	150,000	1.69%
Government Total	*3,984,365*	44.86%
D. Uninsured:		
Uninsured	692,000	7.79%
E. Secondary coverage not accounted for above:		
People with secondary coverage not accounted for above	478,151	5.38%
TOTAL NJ POPULATION	**8,882,190**	

The Institute concluded with a "C Suite" panel moderated by David Gregory of Baker Tilly discussing the lessons learned and post-pandemic recovery efforts for hospitals and health systems. Three chief financial officers provided their perspectives on persisting to provide patient care through a pandemic: Garrick Stoldt, St. Peter's University Health System; Tom Bolsonaro, Inspira Health Network; and Herb White, Hunterdon Healthcare.

Panelists covered several topics including price transparency, telehealth, supply chain issues and the challenges of maintaining a corporate culture when so many are working remote. All three expressed concerns about the potential adverse effects of deferred care on their patient populations as well as having to deal with long Covid. Stoldt noted that pandemic-related shortages brought out both the best and the worst in vendors. While many worked to provide needed supplies at pre-pandemic prices, some took advantage of the shortages.

Save the Date

Pandemic permitting, the 46th Annual Institute will be held at the Borgata next October 19-21, 2022. Mark your calendars and save the dates!

About the Authors

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


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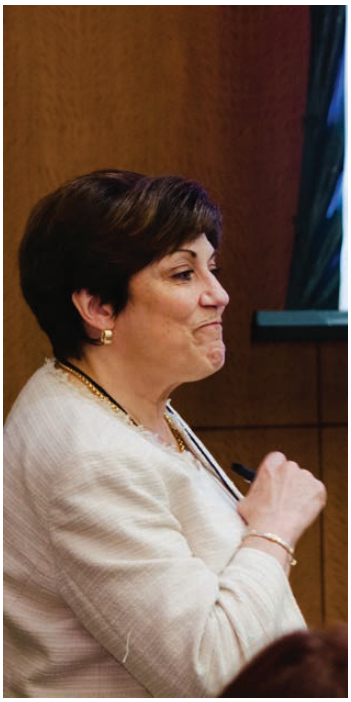


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•Who's Who in NJ Chapter Committees•

2021-2022 Chapter Committees and Scheduled Meeting Dates

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

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

COMMITTEE	PHONE	DATES/TIME/ ACCESS CODE	MEETING LOCATION
CARE (Compliance, Audit, Risk, & Ethics)			
Chair: Fatimah Muhammad – fmuhammad@saintpetersuh.com	(732) 745-8600 x8280	First Thursday of the month	Conference Call
Co-Chair: Ryan Peoples – Peoples2@virtua.org	(856) 355-0729 x50729	9:00 AM	(667) 770-1469
Board Liaison: Fatimah Muhammad – fmuhammad@saintpetersuh.com	(732) 745-8600 x8280	Access Code: 473803	
Communications / FOCUS			
Chair: Scott Besler **(Editor)** – scott.besler@toyonassociates.com	(732) 598-9608	First Thursday of each month	Conference Call (667) 770-1479
Board Liaison: Brian Herdman – bherdman@cbiz.com	(609) 918-0990 x131	10:00 AM Access Code: 868310	In-person Meetings by Notification
Education			
Chair: Hayley Shulman – hshulman@withum.com	(973) 532-8885	Second Friday of the Month	Zoom Meeting
Co-Chair: Sandra Gubbine – Sandra.Gubbine@atlanticare.org	(609) 484-6407	9:00 AM	(667) 770-1298
Co-Chair: Lisa Weinstein – lisa.weinstein@bancroft.org	(856) 348-1190	Access Code: 89425417190	via Zoom
Board Liaison: Kim Keenoy – kim.keenoy@bofa.com	(732) 321-5935		
Certification (Sub-committee of Education)		See Schedule for	
Chair: Amina Razanica – arazanica@njha.com	(609) 275-4029	Education Committee	
Board Liaison: Chair: Amina Razanica – arazanica@njha.com	(609) 275-4029		
FACT (Finance, Accounting, Capital & Taxes)			
Chair: Alex Filipiak – Alexander.Filipiak@rwjbh.org	(732) 789-0072	Third Wednesday of each month	Conference Call
Co-Chair: Hanna Hartnett – Hanna.Hartnett@atlentcare.org	(609) 569-7419	8:00 AM	(872) 240-3212
Board Liaison: Dave Murray – dmurray@rumcsi.org	(856) 298-6629	Access Code: 720-430-141	via GoToMeeting
Institute 2021			
Chair: Maria Facciponti – facciponti.maria@gmail.com	(973) 583-5881	Third Monday of each month	Conference Call
Co-Chair: Brian Herdman – bherdman@cbiz.com	(609) 918-0990 x131	2:00 PM	(717) 908-1977
Co-Chair: Stacey Medeiros – Stacey.Medeiros@pennmedicine.upenn.edu	(609) 423-8731	Access Code: 865290	
Board Liaison: Maria Facciponti – facciponti.maria@gmail.com	(973) 583-5881		
Membership Services/Networking			
Chair: Nicole Rosen – nrosen@acadia.pro	(862) 325-5906	Third Friday of each month	Conference Call
Co-Chair: John Byrne – JByrne56@gmail.com	(917) 837-2302	9:00 AM Access Code: 267693	In person Meetings
Board Liaison: Heather Stanisci – hstanisci@ArcadiaRecovery.com	(862) 812-7923	(667) 770-1400	by notification
Patient Access Services			
Chair: Daniel Demetrops – ddemetrops@medixteam.com	(845) 608-4866	Second Thursday of each month	Conference Call
Co-Chair: Jacqueline Lilly – jacqueline.lilly@atlanticare.org	(609) 484-6408	at 4:00PM	(667) 770-1453
Board Liaison: Amina Razanica – arazanica@njha.com	(609) 275-4029	Access Code: 196273	
Patient Financial Services			
Chairman: Marco Coello – mcoello@affiliatedhmg.com	(973) 390-0445	Second Friday of each month	Conference Call
Co-Chair: Steven Stadtmauer – sstadtmauer@csandw-llp.com	(973) 778-1771 x146	10:00 AM	(717) 908-1928
Board Liaison: Maria Facciponti – maria.facciponti@elitereceivables.com	(973) 583-5881	Access Code: 120676	
Payer/Provider Collaboration			
Chair: Tracy Davison-DiCanto – tracy.Davison-DiCanto@scasurgery.com	(609) 851-9371	Contact Committee	
Board Liaison: Lisa Maltese-Schaaf – LMaltese-Schaaf@childrens-specialized.org	(732) 507-6533	for Schedule	
Physician Practice Issues Forum			
Chair: Michael McLafferty – michael@mjmaes.com	(732) 598-8858	Third Wednesday of the Month	In person Meetings
Board Liaison: Erica Waller – erica.waller@pennmedicine.upenn.edu	(609) 620-8335	8:00AM	with call in available
			via WebEx (Contact Committee)
Regulatory & Reimbursement			
Chair: Jason Friedman – Jason.friedman@atlantichealth.org	(973) 656-6951	Third Tuesday of each month	Conference Call
Co-Chair: Chris Czvornyek – chris@hospitalalliance.org	(609) 989-8200	9:00 AM	(667) 770-1419
Board Liaison: Scott Besler – scott.besler@toyonassociates.com	(732) 598-9608	Access Code: 382856	
Revenue Integrity			
Chair: Tiffani Bouchard – tbouchard@panaceainc.com	(651) 272-0587	Second Wednesday of each month	Conference Call
Board Liaison: Jonathan Besler – jbesler@besler.com	(732) 392-8238	9:00 AM Access Code: 419677	(667) 770-1275
CPE Designation			
Chair: Lew Bivona – lewcpa@gmail.com	(609) 254-8141		

Why You Can't Afford to Wait on Your COB Denials

Lorrie Wood

by Lorrie Wood, CRCR

Up to 65% of denied claims are never corrected and resubmitted for reimbursement. In the case of coordination of benefits (COB) denials and other patient information denials, that's a substantial source of missed revenue, given that 70% of COB denials are approved after they are corrected and resubmitted.

COB denials rank among the most common hospital denials. Since 2014, when the Affordable Care Act prohibited insurance companies from denying coverage for preexisting conditions or charging higher premiums to those who have them, providers have seen a substantial increase in COB denials. Also on the rise: patient involvement denials, or instances where health plans request additional information from patients to process the claims, such as eligibility information updates or prior medical history forms.

Often when hospitals receive COB denials, revenue cycle staff–after trying to reach the patient by phone and by letter–identify these denials as "patient responsibility" and charge the patient a self-pay rate. When this happens, revenue cycle teams leave insurance money on the table. The revenue opportunity can be substantial: At one multi-hospital health system in the East, failing to recover insurance dollars by correcting COB claims cost the health system over $1.2 million in lost revenue per month across 255 patients. The impact per year: $15.3 million in missed revenue across 3,000 patients.

Further, a report from the Council for Affordable Quality Healthcare found that while the number of COB transactions performed by healthcare organizations increased from 2019 to 2020, the healthcare industry could still save $19 million by strengthening efficiency around these transactions.

The financial pressures hospitals face demand a better approach. Patients who have insurance shouldn't be designated self-pay patients when COB denials present challenges for revenue cycle staff. As the percentage of COB denials rises, there are four reasons healthcare providers can't afford to wait to improve their process.

No. 1: Significant potential for increased revenue recovery. COB and patient Involvement denials put up to 1% of net patient revenue at risk. Sometimes, these claims stem from annual or biannual COB update requests. Other common causes include:

- Incomplete or inaccurate COB information on file with the payer
- Care may be covered by another payer
- Medicare Common Working File issues

When hospitals attempt to resolve COB denials on their own, their recovery rate typically totals 30 percent, on average. This figure rises to as high as 75% when organizations invest in outside support. It's a move that empowers hospitals to deploy staff to more value-added work while significantly strengthening their bottom line.

EXHIBIT ONE:

COB & Patient Info Denials Program [1]	Health System	Outsourced COB Program
Annual COB & Patient Info Denials $ (Net) [2]	$36,525,000	$36,525,000
Recovery %	30.0%	75.4%
Revenue from COB Recoveries	$10,957,500	$27,539,850
Revenue Improvement		$16,582,350

1 Based on an RSource analysis of a multi-hospital health system.
2 Approximately 1% of the Health System's annual net patient revenue.

No. 2: Implications for patient satisfaction and the patient financial experience. COB denials are confusing for patients, and they can cause enormous turmoil at a time when patients might already feel vulnerable due to their health status. In one highly publicized incident, a couple from Kansas whose infant daughter spent seven days in neonatal intensive care following complications during delivery were charged $270,951 for labor and delivery and NICU care. The reason: The parents weren't aware of the "birthday rule," which required the daughter's primary coverage to fall under her father's insurance plan. Because the mother's insurance plan was more generous, the parents had thought they would enroll their daughter only in that plan. The situation took two years to resolve, leaving a bad impression on the family.

That's why it's crucial that healthcare revenue cycle departments invest in the resources needed to resolve COB and patient involvement claims. Given that these patients have insurance, they expect the majority of their care to be covered by their plan. When denials arise, revenue cycle departments must serve as an advocate for the patient, working with the insurance company to resolve issues that impede payment.

The challenge lies in putting the missing pieces together. To resolve COB claims, revenue cycle staff must understand the intricacies of COB requirements–including the birthday rule–to determine whether the correct payer was billed as the primary health plan. They must contact patients to confirm coverage. They must also assess whether secondary and/or tertiary coverage exists, in part by reviewing all associated accounts within the billing system. These can be time-consuming tasks. Revenue cycle leaders must consider: "Is my staff's time best spent on these activities? Or, is there greater return on investment from outsourcing this work?"

No. 3: The opportunity to markedly reduce bad debt. If your organization isn't actively correcting payers acting in bad faith or with lack of fairness around COB claims, your chances of preventing and mitigating other types of denied or delayed claims also plummets. Payers will perceive a lack of action as a sign of complacency, and they will have limited incentive to work with your organization to resolve issues that arise.

Every payer contract contains an implied covenant of good faith and fair dealing. When a payer violates this covenant–such as by asking for COB just to delay paying the claim, failing to release claims even when the COB forms are on file, or relying on timely filing rules to deny claims in unjustifiable, unfair circumstances–hospitals need a strategy for recovering revenue for services delivered. The question is, does your organization have the time and expertise to hold payers accountable in scenarios such as these? Further, would the time and effort spent responding to COB denials match the recovery rates and timeframes of a third-party expert?

One important consideration is that a COB denial may need to be reprocessed more than once before an organization receives payment. This effort requires not just persistence, but also careful tracking of which claims were resubmitted, when, and the status of recovery efforts across claims and health plans.

No. 4: The importance of timely engagement in optimal revenue recovery. COB claim denials are complex, and many cannot be resolved without the patient's assistance. This puts pressure on staff to not only engage the right payer in a timely manner, but also the patient. Revenue staff tasked with contacting patients must possess a strong understanding of how to effectively gain patients' full involvement.

In our experience, multi-channel communications–from texts to emails, auto dialers and letters–are needed to produce optimal results. In fact, we've found that the style of envelope matters when mailing print communications, with colorful envelopes and mailers more likely to spark a response than standard business envelopes. Further, the time of day when contact is attempted makes a difference in whether a patient responds and how quickly a response is received.

Typically, a "once and done" approach to communication is not sufficient. Providers must plan to frequently contact the payer to determine whether an issue is still outstanding. They must also have a robust strategy for patient follow-up when additional information is needed. Because so much handholding is involved, hospital revenue cycle teams often find that they need third-party assistance in initiating and managing these conversations if they are to achieve the desired recovery rate.

An Ounce of Prevention

Overturning COB denials is complex work, but hospital revenue cycle teams needn't go it alone. By investing in a more strategic model for preventing and responding to COB denials, with a focus on the right support at the right time, hospitals can more effectively bolster recovery rates while strengthening the patient financial experience.

About the author:

Lorrie Wood, CRCR, is Chief Client Officer for RSource, which provides innovative third-party solutions that improve revenue cycle performance for hospitals. She may be reached at lwood@rsource.com

Find out how Yale New Haven Health turned around its cash collections and improved aging accounts receivable and the patient financial experience by creating a more sustainable approach to COB denials management. Read the case study.

•Focus on Finance•

Review your Hospital's Community Health Needs Assessment and Implementation Plan!

John Smith

Johanna Orellana

By John Smith and Johanna Orellana

The Patient Protection and Affordable Care Act ("ACA") added new requirements that tax-exempt hospital organizations must satisfy in order to be described in Internal Revenue Code ("IRC") §501(c)(3). Under IRC §501(r)(3) an organization that operates one or more hospital facilities must conduct a Community Health Needs Assessment ("CHNA") and adopt an implementation strategy at least once every three years. The initial failure to comply results in an excise tax of $50,000 per facility per year.

On August 24, 2021, the Journal of the American Medical Association ("JAMA") published an article related to the findings of their study performed on IRC §501(c)(3) tax-exempt hospitals compliance with the requirements of IRC §501(r)(3). The study examined the following: (1) did the organization conduct a triennial CHNA and adopt an implementation strategy; (2) did the organization abide by the specific documentation requirements; and (3) did the organization make these documents widely available to the public.

Q. What are a tax-exempt hospitals requirements under IRC §501(r)(3)?

A. IRC §501(r)(3) requires a tax-exempt hospital organization to conduct a CHNA once every three years for tax years beginning on or after March 23, 2012. In addition, the hospital organization must have an authorized body adopt a written implementation strategy to meet the needs identified in the CHNA.

Conducting a CHNA requires a hospital organization to do the following: (1) define the community served; (2) assess the health needs of the community; (3) solicit and consider input received from persons who represent the broad interests of the community, including those with special knowledge of or expertise in public health; (4) document the CHNA in a written report that is adopted by an authorized body of the hospital facility and (5) make the CHNA report widely available to the public.

In addition, a hospital organization's implementation strategy must be a written plan that, for each significant health need identified, either: (1) describes how the hospital facility plans to address the health need, or (2) identifies the health need as one the hospital facility does not intend to address and indicates why it does not intend to address the particular health need. An authorized body of the hospital facility must adopt the implementation strategy. Generally, this must be done on or before the 15th day of the fifth month after the end of the taxable year in which the hospital facility finishes conducting the CHNA.

Q. What were the findings of the study?

A. JAMA performed a search via ProPublica Nonprofit Explorer to identify 1,662 tax-exempt hospitals in the United States. The study randomly selected 500 of the tax-exempt hospitals which their respective Form 990; Schedule H was downloaded for review to assess compliance with CHNA requirements. The findings were as follows: 495 (99%) hospitals reported on their Form 990 that a CHNA was conducted, of these, 412 (84%) CHNAs were identified on the tax-exempt hospitals website. There were 491 (99%) hospitals which reported that an implementation strategy was adopted, of these, 331 (75%) were identified on the tax-exempt hospital's website. In conclusion, it was determined that only 229 (60%) of the tax-exempt hospitals selected for this study had both a CHNA and implementation strategy on their website.

Q. What deficiencies did the study uncover?

A. The study uncovered significant deficiencies with tax-exempt hospital organizations' CHNAs and implementation strategies. Some of the more frequent findings include: missing required documentation; not including an evaluation of impact of any actions that were taken to address the significant needs identified; and not describing available resources to address the health needs identified. Although most tax-exempt hospitals reported on their Form 990, Schedule H that they conducted a CHNA and adopted an implementation strategy accordingly, only 60% of the hospitals reviewed actually fully satisfied the requirements of IRC §501(r)(3).

Q. What were the quality scores for CHNA reports by documentation requirement?

A. The CHNAs had a mean quality score of 3.2 out of 5. Many were missing one or more of the IRS requirements outlined in IRC §501(r)(3). The study outlined the CHNA requirements and scores as follows:

CHNA Element	Score, mean (out of 5)
Definition of community	4.17
Methods	4.14
Input from community	3.71
Description of underserved community	2.39
Prioritization of health needs	2.8
Resources available	3.24
Evaluation of impact since last CHNA	2.13

Q. How can your organization stay in compliance?

A. Withum recommends the following for tax-exempt hospitals with respect to staying compliant with the Regulations under IRC §501(r)(3):

- Review your most recent CHNAs in conjunction with the IRS requirements
- Coordinate a review of the Form 990 Schedule H CHNA questions and answers and applicable disclosures consistent with your CHNA and implementation plan
- Designate a responsible person from your organization to lead IRC §501(r)(3) compliance
- Form a community benefit committee
- Involve senior management and the Board
- Review your organization's website and make sure the last two required CHNAs are posted on the organization's website.
- Check your organization's CHNA and other documents website links regularly.

Conclusion

Form 990 Schedule H incorporates questions regarding a tax-exempt hospital facility's CHNA and implementation plan, including the URL's where these reports should be posted and made widely available. The Form 990 is open for public disclosure and in today's hostile environment with respect to hospitals and tax-exemption an organization needs to be careful to comply with all IRS, state, and local tax-related requirements. The Internal Revenue Service ("IRS") continues to conduct reviews of tax-exempt hospital's compliance with IRC §501(r)(3) and if an auditor cannot easily find a tax-exempt hospital's CHNA or implementation strategy it is an easy way to be selected for a compliance check, imposition of excise taxes and/or a subsequent IRS audit examination.

About the author

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The New Jersey Economic Recovery Act: An Overview of the New Jersey Emerge Program

Steven G. Mlenak

James A. Robertson

by Steven G. Mlenak and James A. Robertson

The New Jersey Economic Recovery Act (ERA), 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 New Jersey Governor Phil Murphy on January 7, 2021 and was subsequently updated by a so-called "clean-up" bill on July 2, 2021.

This article focuses on the New Jersey Emerge Program, enacted as part of the ERA to provide tax credit incentives to encourage job creation and the retention of significant numbers of jobs in imminent danger of leaving New Jersey.

Program Administration and Awards

The New Jersey Emerge Program is being administered by the New Jersey Economic Development Authority (EDA). Applications will be reviewed and decided by the Board of the EDA in accordance with statutory requirements and regulations to be promulgated by the EDA, with oversight provisions to ensure that all jobs promised are delivered. The ERA has appropriated a combined total of $11.5 billion, over a seven-year period, for the Emerge Program and the New Jersey Aspire Program.

The total value of tax credits awarded annually during each of the first six years of the Emerge Program will be capped at $715 million for projects located in northern counties of the state, and $385 million for projects located in southern counties of the state.

The program provides base tax credits of between $250 and $4,000 per retained or newly created job per year (up to 7 years). In addition, bonus annual tax credits are available based upon the use of the project, the number of new full-time jobs created, and other criteria. Such tax credits can be transferred for no less than 85% of their value or, if allowed under New Jersey's annual appropriation act and if funds are available, may be surrendered to the New Jersey Division of Taxation for 90% of the value of the credits. For many businesses, including non-profits (which are eligible for the Emerge Program), this allows them to take advantage of the program even if they might not have corporate business tax or insurance premiums tax to offset.

Eligibility and Application Process

To be eligible for incentive awards under the Emerge Program, the following criteria must be satisfied through an application made by the business's chief executive officer, or equivalent officer:

a) The business must submit an Emerge Program application prior to March 1, 2027 (see note below).
b) The business must make, acquire, or lease a sufficient capital investment (as more specifically defined in the statute) at a qualified business facility (see note below).
c) The business must create or retain full-time jobs at the qualified business facility in a sufficient amount (as more specifically defined in the statute).
d) The business must be located in a qualified incentive area ((a) a population census tract having a poverty rate of 20% or more; or (b) a census tract in which the median family income for the census tract does not exceed 80% of the greater of the statewide median family income or the median family income of the metropolitan statistical area in which the census tract is situated).
e) The business must demonstrate that the award of tax credits is a material factor in the business's decision to create or retain the number of new and retained full-time jobs (see note below).
f) The business must demonstrate that the tax credits awarded will yield a net positive benefit to the state with a minimum net benefit dependent upon the type

of business, project and location (as more specifically defined in the statute).

g) The qualified business facility must comply with minimum environmental and sustainability standards.

h) The business must comply with the EDA's affirmative action requirements.

i) Any worker employed to perform construction work or building services work at the qualified business facility shall be paid not less than prevailing wage, subject to certain exceptions, up to the second anniversary of EDA's first issuance of a certificate of compliance.

j) A business must provide and adhere to a plan that demonstrates that the qualified business facility is capable of accommodating more than half of the business's new or retained full-time employees as approved and must certify, under the penalty of perjury, that not less than 80% of the withholdings of new or retained full-timejobs are subject to the "New Jersey Gross Income TaxAct."

k) The business must commit to retaining the full-time jobs for 1.5 times the length of the incentive award period (i.e., if the applicant chooses to receive tax credits for the maximum of 7 years, it must commit to retaining the jobs for 10.5 years).

l) For bonus tax credits, the jobs must pay at least $15 per hour or 120% of the state's minimum wage rate, whichever is higher.

Note: For items a) and b) listed above, the business's capital investment and number of jobs created or retained requirement must be satisfied within 3 years of the date of approval from the EDA, subject to extensions.

For item e) listed above, to assist the EDA in determining whether the award of tax credits is a material factor in the eligible business's decision to create or retain the minimum number of new and retained full-time jobs for eligibility under the program, the chief executive officer of the EDA will require the eligible business to submit, as part of its application:

- a full economic analysis of all locations under consideration by the eligible business;
- all lease agreements, ownership documents, or substantially similar documentation for the eligible business's current in-state loctions; and
- all lease agreements, ownership documents, or substantially similar documentation for potential out-of-state location alternatives, to the extent they exist.

The chief executive officer of the EDA may further consider the costs associated with opening and maintaining a business in New Jersey, competitive proposals that the eligible business has received from other states, the prevailing economic conditions, and any other factors that the chief executive officer of the EDA

continued on page 24

continued from page 23

deems relevant to assist in determining whether an award of tax credits is a material factor in the eligible business's decision.

In addition, the business must comply with all requirements for filing tax and information returns and for paying or remitting required state taxes and fees by submitting, as part of the application, a tax clearance certificate. Further, the business may not be more than 24 months in arrears at the time of application.

Following approval by the EDA, but before the issuance of tax credits, the EDA will require the business to enter into a project agreement on the terms set forth in the ERA. For any project that exceeds $10 million in total project costs, the developer will be required to enter into a community benefits agreement with the EDA and the county and municipality.

The application for the Emerge Program is now available. In addition to meeting the eligibility requirements set forth above, the Emerge Program requires that the New Jersey Department of Labor and Workforce Development, the New Jersey Department of Environmental Protection, and the New Jersey Department of the Treasury each report to the EDA that the developer is in substantial good standing.

The Emerge Program is incredibly nuanced and therefore does not lend itself to being summarized in a succinct fashion within the limited parameters of this overview. We therefore recommend that interested parties consult with an attorney regarding their business's eligibility for the Emerge Program.

About the Authors:
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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

Payor Contract Analyst III
Atlanticare

Vice President, Payer Relations
Roswell Park Comprehensive Cancer Center

Billing Manager
Atlanticare

Controller
Bayhealth Medical Center

Financial Reimbursement Data Analyst
CBIZ KA Consulting Services

Accountant
Preferred Behavioral Health Group

Physician Practice Systems Data Analyst - Finance
Capital Health

Senior Accountant
Penn Medicine Princeton Health

Senior Vice President Of Finance
Maimonides Medical Center

NJ HFMA Membership and Networking Committee Annual Holiday Social

Wednesday November 17th the HFMA NJ chapter held a networking holiday event at the Chimney Rock Inn in Bridgewater, NJ. The event was so well attended that at the last minute we had to contact the venue and change to the bigger room, thankfully we were able to! We had food, amazing pizza, drinks, and more. Chapter members were able to mingle and network the entire time and I heard that multiple people were able to make good business connections that night. Thank you to our two sponsors that made this event possible; Change Healthcare and Annuity Health!

CMS Issues Final Updates to the Calendar Year (CY) 2022 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Centers (ASC)

Larry Goldberg

by Larry Goldberg

The Centers for Medicare and Medicaid Services (CMS) have issued a final rule with comment period that updates policies and payment rates for services furnished to Medicare beneficiaries in hospital outpatient departments (HOPDs) and in ambulatory surgical centers (ASCs) beginning January 1, 2022 (CY 2022). CMS discusses the requirements for the Hospital Outpatient Quality Reporting (OQR) Program and the ASC Quality Reporting (ASCQR) Program, updates Hospital Price Transparency requirements and they discuss the design of the Radiation Oncology Model.

CMS indicated, "The total increase in Federal Government expenditures under the OPPS for CY 2022, compared to CY 2021, due only to the changes to the OPPS in this final rule with comment period, would be approximately $1.27 billion. Taking into account the estimated changes in enrollment, utilization, and case-mix for CY 2022, CMS estimates that the OPPS expenditures, including beneficiary cost-sharing, for CY 2022 would be approximately $82.1 billion, which is approximately $5.9 billion higher than estimated OPPS expenditures in CY 2021."

Updates To Requirements For Hospitals To Make Public A List Of Their Standard Charges

CMS finalized the following policies in this rule: (1) increasing the dollar amount of penalties for noncompliance through the use of a scaling factor based on hospital bed count; (2) deeming state forensic hospitals that meet certain requirements to be in compliance with the requirements of 45 CFR part 180, and (3) requiring that the machine-readable file be accessible to automated searches and direct downloads.

CMS is increasing the civil monetary penalties (CMP) for hospitals failing to comply with its "Price Transparency" requirements. Thus, a full calendar year of noncompliance, will be a minimum total penalty amount of $109,500 per hospital, and a maximum penalty amount would be $2,007,500 per hospital (depending on bed size), as shown in the table below.

Application of CMP Daily Amounts for Hospital Noncompliance for CMPs Assessed in CY 2022 and Subsequent Years

Number of Beds	Penalty applied per day	Total penalty amount for full calendar year of noncompliance
30 or less beds	$300 per hospital	$109,500 per hospital
31 up to 550 beds	$310 to $5500 per hospital (Number of beds times $10.00)	$113,150-$2,007,500 per Hospital
>550	$5,500 per hospital	$2,007,500 per hospital

Should CMS conclude that a hospital is noncompliant with one or more of the requirements to make public standard

charges, CMS may take any of the following actions, which generally may occur in the following order:

- Provide a written warning notice to the hospital of the specific violation(s).
- Request a corrective action plan from the hospital if its noncompliance constitutes a material violation of one or more requirements.
- Impose a CMP not in excess of $300 per day, on the hospital and publicize the penalty on the CMS website if the hospital fails to respond to CMS' request to submit a corrective action plan or comply with the requirements of a corrective action plan.

A Few Major Provisions…

For CY 2022, CMS is increasing the payment rates under the OPPS by an Outpatient Department (OPD) fee schedule increase factor of 2.0 percent. This increase factor is based on the hospital inpatient market basket percentage increase of 2.7 percent for inpatient services paid under the hospital inpatient prospective payment system (IPPS) reduced by a proposed productivity adjustment of 0.7 percentage point.

Data used in CY 2022 OPPS/ASC Rate-setting and Partial Hospitalization:

Because the CY 2020 claims data include services furnished during the COVID-19 Public Health Emergency (PHE), which significantly affected outpatient service utilization, CMS has determined that CY 2019 data would be a better expected CY 2022 outpatient service utilization than the CY 2020 data. As a result, CMS is utilizing CY 2019 data to set CY 2022 OPPS and ASC payment rates. For Partial Hospitalization, CMS will maintain the CY 2021 per diem costs in CY 2022.

Changes to the Inpatient Only (IPO) List:

CMS is finalizing its proposal with modification to pause the elimination of the ASC IPO list and add back the IPO list the services removed in 2021 with the following few exceptions--CPT codes: 00630; 00670; 01486; 01638; 22630; 23472 and 27702. CMS is also classifying CPT code 0643T as an inpatient only procedure.

Medical Review of Certain Inpatient Hospital Admissions under Medicare Part A for CY 2021 and Subsequent Years (2-Midnight Rule):

For CY 2022, CMS is finalizing a policy to exempt procedures that are removed from the inpatient only (IPO) list under the OPPS beginning on or after January 1, 2022, from site-of-service claim denials, Beneficiary and Family-Centered Care Quality Improvement Organization (BFCC-QIO) referrals to Recovery Audit Contractor (RAC) for persistent noncompliance with the 2-midnight rule, and RAC reviews for "patient status" (that is, site-of-service) for a time period of 2 years.

340B-Acquired Drugs:

For CY 2022, CMS is continuing its current policy of paying an adjusted amount of Average Sales Price ("ASP") minus 22.5 percent for drugs and biologicals acquired under the 340B program. CMS is continuing to exempt Rural SCHs, PPS-exempt cancer hospitals and children's hospitals from its 340B payment policy.

Device Pass-Through Payment Applications:

For CY 2022, CMS notes it received eight applications for device pass-through payments. One of these applications (the Shockwave C^2 Coronary Intravascular Lithotripsy (IVL) catheter) received preliminary approval for pass-through payment status through CMS' quarterly review process. Of the remaining seven, only two were approved.

Ambulatory Surgery Centers (ASC) Payment Update:

For CYs 2019 through 2023, CMS adopted a policy to update the ASC payment system using the hospital market basket update. Using the hospital market basket methodology, for CY 2022, CMS is increasing payment rates under the ASC payment system by 2.0 percent for ASCs that meet the quality reporting requirements under the ASCQR Program. CMS estimates the payments to ASCs for CY 2022 will be approximately $5.41 billion, an increase of approximately $40 million compared to estimated CY 2021 Medicare payments.

ASC Payment Policy for Non-Opioid Pain Management Drugs and Biologicals under Section 6082 of the SUPPORT Act (Section 1833(t)(22) of the Social Security Act):

CMS is finalizing its proposal that beginning January 1, 2022, a non-opioid pain management drug or biological that functions as a surgical supply in the ASC setting would be eligible for separate payment when such product is FDA approved, FDA indicated for pain management or as an analgesic, and has a per-day cost above the OPPS drug packaging threshold, which is finalized at $130. CMS says there are four drugs meeting this test.

Changes to the List of ASC Covered Surgical Procedures:

For CY 2022, CMS is re-adopting the ASC Covered Procedures List (CPL) criteria that were in effect in CY 2020. CMS notes that it has determined that a total of six procedures should either remain on or be added to the CPL.

About the author

Larry Goldberg is a Senior Advisor for Third Party Reimbursement Solutions, LLC ("TPR"). He has more than 45 years of health care finance knowledge. Larry is a recognized expert on Medicare payment issues and frequently makes speeches at HFMA conferences (Northeast and National) regarding federal payment legislation and regulations and the ever changing perspectives in Washington, DC regarding health care. Larry can be reached at Larry004b@gmail.com.

2021: Pandemic Year Two – How Did the U.S. Do?

John Dalton

by John Dalton, FHFMA

The new year dawned on a note of cautious optimism: Operation Warp Speed had produced breakthrough vaccines from Pfizer and Moderna[1] that received emergency use authorizations (EUAs) in December 2020, and the new administration taking office in January had promised an all-out war on the pandemic. On the day he was inaugurated, President Biden's first three Executive Orders targeted Covid-19[2]. More than 200 million vaccine doses were administered during the first 100 days of the new administration, resulting in a near-normal summer throughout the U.S.

However, the June emergence of the highly transmissible and virulent Delta variant coupled with vaccine hesitancy prompted by widespread misinformation led CDC Director Dr. Rochelle Walensky to declare that the outbreak in the U.S. is becoming "a pandemic of the unvaccinated."[3] She noted that nearly all hospital admissions and deaths were among those who had not been immunized. Unfortunately, many states chose to ignore CDC recommendations and, on September 21, the autumnal equinox, the U.S. death toll surpassed the 675,000 Americans who perished in the 1918-19 flu pandemic. The post-Thanksgiving emergence of the outrageously contagious (but less virulent) Omicron variant caused 2021 to end with a feeling of extreme pandemic fatigue and more than 825,000 American deaths.

This article will briefly examine how the U.S. performance compared with other developed countries – the 37 member nations of the Organization for Economic Cooperation and Development (OECD) – and highlight some of the states whose refusal to heed public health guidance caused America to once again plummet in the OECD rankings.

Help is on the way

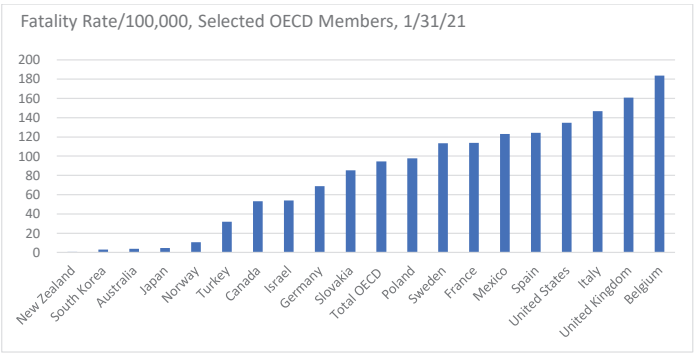
When President Biden took office, the death toll in the U.S. was at 407,000, with a per capita fatality rate higher than 31 of the OECD's 37 member nations, trailed only by Italy, the Czech Republic, the U.K., Slovenia and Belgium (see chart, "Fatality Rate/100,000, Selected OECD Members, 1/31/21"). Germany ranked 16th, France 27th and our neighbor to the north, Canada was 11th.

During his Inaugural Address, Biden asked for a moment of silent prayer, stating: "We're entering what may be the toughest and deadliest period of the virus and must set aside politics and finally face this pandemic as one nation." 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."[4]

Later that day, Biden headed to the Oval Office. "I thought there's no time to wait. Get to work immediately," he said, and his first three Executive Orders targeted Covid-19: requiring masks on federal property, rejoining the World Health Organization (WHO) and establishing a White House Covid-19 response team led by Jeff Zients.[5]

Biden vowed to overcome Covid, trying to rally Republicans to join Democrats behind a "war" on the global pandemic. The Trump team had refused to confer with the Biden team during the transition period, who found that the previous administration did not have a plan for federal delivery of Covid vaccines. Instead, their intent was to simply give vaccines to the states and then let the cash-strapped states figure out how to get them injected into arms. "What we're inheriting is so much worse than we could have imagined," Biden's coronavirus response coordinator, Jeff Zients, said to reporters on January 21.

Biden immediately invoked the Defense Production Act,[6] purchased more vaccines, worked with states to establish vaccine sites and transportation to them, and established vaccine centers in pharmacies across the country. As vaccination rates climbed, he vowed to make sure that 70% of the U.S. adult population would have one vaccine shot and 160 million U.S. adults would be fully vaccinated by July 4th. More than 200 million vaccine doses were administered during the first 100 days of the new administration. By late April, more than half of adult Americans



had at least one shot, including 80% of those over 65.[7] However, the rate of daily vaccinations began to decline due in part to the pause in J&J's single shot vaccine because of concerns about blood clots. That negative news triggered an acceleration in vaccine misinformation being spread on print, broadcast and social media. At July 4th, 157.3 million Americans were fully vaccinated, 98.3% of President Biden's ambitious goal.

Delta Dawns

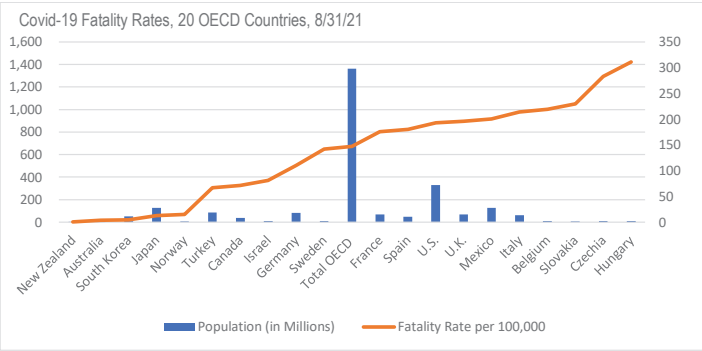
In early June, U.S. Surgeon-General Dr. Vivek Murthy issued a warning: "For those who are unvaccinated, they are increasingly at risk as more and more variants develop," specifically citing the B.1.617.2, or Delta variant, first identified in India.[8] "The news about the Delta variant is evidence of really why it's so important for us to get vaccinated as soon as possible," he said, adding that the variant is more transmissible and potentially more dangerous. The executive director of the WHO's health emergencies program Dr. Michael Ryan stated, "This particular Delta variant is faster, it is fitter, it will pick off the more vulnerable more efficiently than the previous variants."[9]

A July report from the Commonwealth Fund found that the aggressive vaccination campaign markedly curbed the U.S. pandemic. Without it, there would have been about 279,000 more deaths and 1.25 million more hospitalizations. They concluded: "Our results demonstrate the extraordinary impact of rapidly vaccinating a large share of the population to prevent hospitalizations and deaths. The speed of vaccination seems to have prevented another potential wave of the U.S. pandemic in April that might otherwise have been triggered by the Alpha and Gamma variants."[10]

Despite the Commonwealth Fund's findings and the stern warnings from Dr. Murthy and Dr. Ryan, vaccine hesitancy persisted, leading CDC Director Dr. Rochelle Walensky to warn that the outbreak in the U.S. was becoming "*a pandemic of the unvaccinated*" because nearly all hospital admissions and deaths are among those who hadn't been immunized.

From February through August 2021, the U.S. climbed steadily in the OECD rankings to 26th of 37 countries at August month end (see chart, "Covid-19 Fatality Rates/100,000, 20 OECD Countries, 8/31/21"). The U.K. ranked 28th, France 24th and Germany 15th. Our neighbor to the north, Canada, moved into 10th place behind the four Pacific Rim countries (Australia, Japan, New Zealand and South Korea), four of the Scandanavian countries (Denmark, Finland, Iceland and Norway) and Turkey.

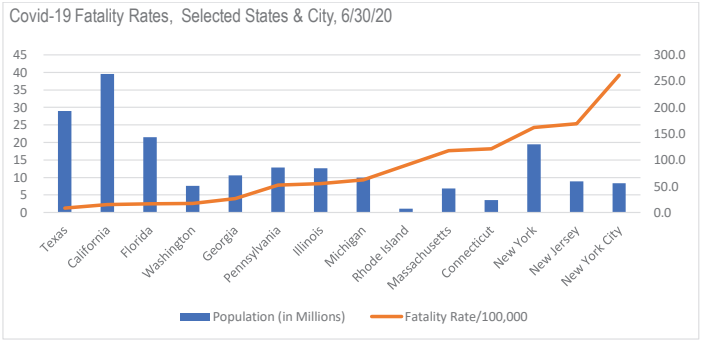
Belgium had spent all of 2020 and the first two months of 2021 in last place among the OECD's member nations. By August month-end, the Slovak and Czech Republics, Colombia and Hungary had fallen to the bottom of the rankings.



States Role in the Fall Fall

To better understand states 2021 performance, a brief review of the pandemic's 2020 beginnings is needed. On New Year's Eve, December 31, 2019, the WHO's China office was informed of cases of pneumonia of unknown cause detected in Wuhan City, Hubei Province of China. Three weeks later, the U.S. confirmed its first case in Washington state – a man in his 30s developed symptoms after returning from Wuhan. The WHO declared Covid-19 a global health emergency on January 30 and a global pandemic on March 11.

Initial outbreaks in Milan and Madrid spread rapidly. 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. By mid-year, the Northeast had the highest per capita fatality rates in the country (see chart "Covid-19 Fatality Rates, Selected States & City, 6/30/20"). At June 30, Belgium had the highest per capita fatality rate/100,000 in the OECD at 85.1. All five northeastern states on the chart were higher, topped by New Jersey at 169.1, double Belgium's worst in the OECD performance. The challenge ahead was clear. Development of safe, effective vaccines to prevent infection and therapeutics to treat infections needed to have a top priority. Meanwhile, schools pivoted to remote learning and Health and Human Services Secretary Alex Azar's mantra: "Wash your hands, watch your distance, wear a mask" became the order of the day.



Operation Warp Speed, a public-private partnership to facilitate and accelerate the development and distribution of Covid-19 vaccines, therapeutics and diagnostics, was announced

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in mid-May.[11] Arguably the most effective response to the coronavirus undertaken by the Trump administration, it was funded initially with $10 billion from the CARES Act.

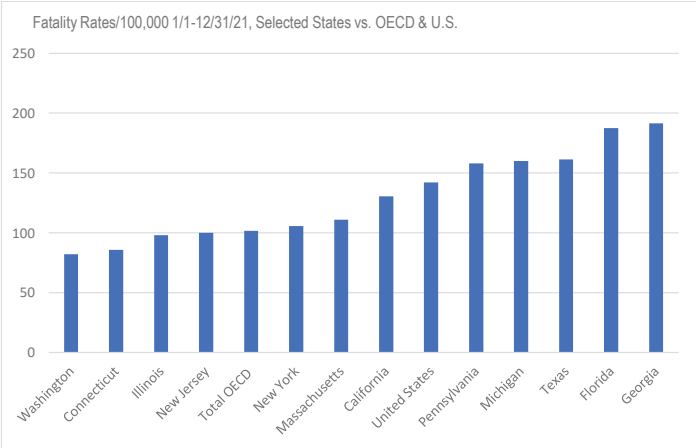
Companies receiving funding for vaccine development included Johnson & Johnson (Janssen Pharmaceutical), Moderna, Novovax, Astra Zeneca and the University of Oxford, Merck and IAVI, and Sanofi and Glaxo Smith Kline. Pfizer/BioNTech participated in Operation Warp Speed but did not accept any governmental funding.

During November, both Pfizer and Moderna announced that their experimental vaccines were highly effective in preventing disease.[12] Both vaccines consist of genetic material, messenger RNA (mRNA), encased in tiny particles that shuttle it into cells, then train the immune system to recognize the spiked protein on the surface of the virus. Since the vaccines are not made with the coronavirus itself, there's no chance anyone could catch it from either of these shots. Both vaccines require two doses for full effectiveness. Pfizer's vaccine requires deep freeze storage but can be kept at refrigerator temperatures for up to five days. The Moderna vaccine can be stored in a freezer and is stable at refrigerator temperatures for up to 30 days.

Both vaccines received emergency use authorization (EUA) from the FDA in early December. On December 14, the first doses of the Pfizer/BioNTech were administered and America began a vaccine vs. variants race to recovery.[13]

That same day, the U.S. death toll surpassed 300,000, roughly equivalent to the population of St. Louis or Pittsburgh.

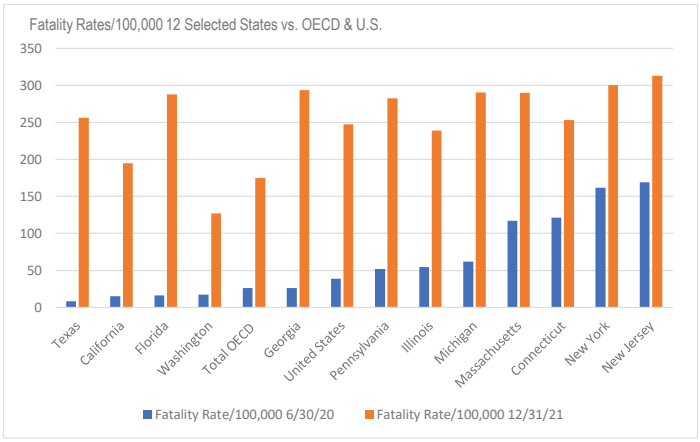
Looking solely at calendar year 2021, here's how 12 of the most populous states compared to both the OECD and the U.S. per capita fatality rates:



During calendar year 2021, the U.S. per capita fatality rate of 142.3/100,000 continued to outpace the OECD (101.6/100,000), but Washington, Connecticut, Illinois and New Jersey managed per capita fatality rates lower than the OECD average for the year. At the other extreme, the per capita fatality rates in Florida and Georgia are about a third higher than the U.S. average and nearly double the OECD average.

Dr. Thomas Frieden's January 2, 2021 Wall Street Journal article identified the countries that, in his opinion, had done the best job of responding to the pandemic.[14] He was CDC Director from 2009-2017 and gave high marks to Denmark, Finland, Hong Kong, Liberia, New Zealand, Sout Korea and Taiwan. Critical of the U.S. response, he noted that "Bad politics, quite simply, can trump good public health."

Another way of visualizing the effectiveness of state leadership is to look at the change in fatality rates since mid-year 2020, after the initial Covid-19 surge had run its devastating course. The chart below shows the same 12 states and their per capita fatality rates on June 30, 2020 compared to December 31, 2021. Early on, Texas, California and Florida had per capita fatality rates lower than the OECD average, but that didn't last. Only Washington has been able to protect its residents better than the OECD average over the course of the pandemic to date.

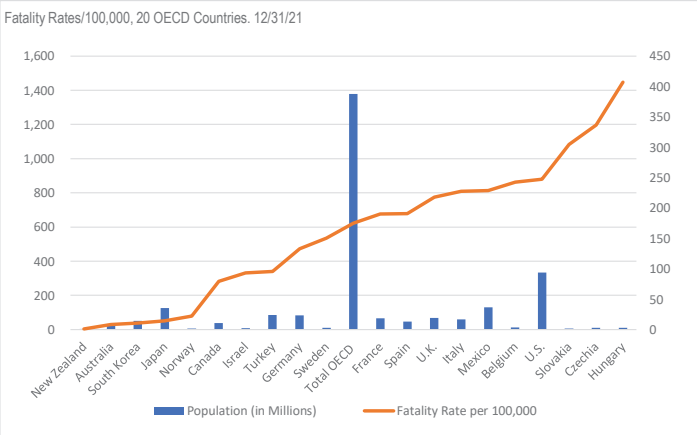


New Jersey and New York were hard hit early in the pandemic and, until the fall of 2021, had consistently had the highest per capita fatality rates in the U.S. By year end, Alabama, Louisiana, Arizona and Mississippi all had higher per capita fatality rates, with Georgia and Florida catching up fast. Sadly, these states placed politics above public health guidance.

For example, in fall 2020, Florida Governor Ron DeSantis insisted that all schools open with a normal five day a week schedule and threatened to withhold school aid if they did not. In fall 2021, he threatened to not pay county superintendents who required masks to protect their students. Most recently, the state's Agency for Health Care Administration threatened to issue fines of up to $50,000 per violation to hospitals that require employees to wear masks.[15]

Thus, it should come as no surprise that the U.S. slipped from 26th at August 31 to 31st at year end in the OECD's per capita fatality rates (See "Table 1. Confirmed Cases and Fatality Rates, OECD Countries as of 12/31/2021," following this article), trailed only by Colombia and six former Soviet

satellites (Poland, Slovenia, Lithuania, Czech Republic, Slovak Republic and Hungary). Israel replaced Turkey in the top ten while Canada moved up to the 9th place slot. The four Pacific Rim countries and four Scandanavian countries continued to lead the world in protecting their residents from the ravages of SARS-CoV-2. Whether it was the Alpha, Delta or Omicron variant, these countries put public health and science above politics and it worked.



With more than 825,000 deaths at year end, the U.S. death toll had surpassed the 2018-19 pandemic's toll by 150,000. Overall, America has done a poor job of protecting its residents. If the U.S. had merely matched the OECD's average fatality rate/100,000 of 175.0, 240,000 more Americans would be alive today. If the U.S. had matched Germany's performance (133.1/100,000), 380,000 more Americans would be alive today. If the U.S. had matched Canada (79.4/100,000), 560,000 more Americans would be alive today.

What Next?

In his recent interview with STAT, the WHO's Dr. Michael Ryan said "What's shocked me most in this pandemic has been that absence or loss of trust," people's unwillingness to follow the advice of public health leaders and the containment policies set out by governments.[16] "In the end, the virus doesn't have a brain. It's just…exploiting opportunities."

Given the opportunity to replicate, the virus will continue to mutate. This author's mantra for 2022 is:

" **Vaccination + Mitigation Stops Replication!**" Be careful out there.

About the Author

John J. Dalton, FHFMA, is Senior Advisor Emeritus at BESLER, Editor of Healing American Healthcare Coalition's newsletter, the Three Minute ReadTM and coauthor of ***"Healing American Healthcare – Lessons from the Pandemic,"*** *available from Amazon and Apple as well as at a discounted rate at the Healing American Healthcare Coalition's web site. John received HFMA's 2001 Morgan Award for lifetime achievement in healthcare financial management and was named 2017 Hospital Trustee of the Year by NJHA. Feel free to contact him with your thoughts and comments at jjdalton1@verizon.net.*

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[2]Biden looks to galvanize Covid-19 fight, vaccinations as he takes office, by Susan Heavey, Patricia Zengerle, Reuters, 1/20/21

[3]Covid-19 'is becoming a pandemic of the unvaccinated,' CDC director says, by Heather Hollingsworth and Josh Funk, Associated Press, 7/16/21

[4]Biden signs burst of virus orders, vows 'Help is on the way.' By Ricardo Alonso-Zalvidar and Zeke Miller, Associated Press, 1/21/21

[5]Here's What's in Biden's Executive Orders Aimed at Curbing the Pandemic, by Noah Weiland, New York Times, 1/22/21

[6]Biden Says He Invoked Production Law For More Vaccine Doses, by Justin Sink, Josh Wingrove and Jennifer Epstein, Bloomberg, 2/16/21

[7]Biden Says Goal Of 200 Million Covid-19 Vaccinations in 100 Days Has Been Met, by Brian Naylor, NPR, 4/21/21

[8]U.S. Surgeon General warns unvaccinated people are at risk from a potentially more dangerous Covid-19 variant, by Travis Caldwell, CNN, 6/10/21

[9]WHO says delta is the fastest and fittest Covid variant and will 'pick off' most vulnerable, by Berkeley Lovelace, Jr., CNBC, 6/22/21

[10]Deaths and Hospitalizations Averted by Rapid U.S. Vaccination Rollout, by Allison Galvani, Seyed M. Moghadas and Eric C. Schneider, The Commonwealth Fund, 7/7/21

[11]Trump announces 'Operation Warp Speed,' says U.S. could have coronavirus vaccine by January, by Elizabeth Weise, USA Today, 5/15/21

[12]Moderna, Pfizer Shots Look Strong. Here's How They Stack Up, by James Paton, Bloomberg, 11/16/20

[13]The first public Covid-19 vaccines reach all states as the U.S. death toll tops 300,000, by Susannah Cullinane, Holly Yan and Ralph Ellis, CNN, 12/14/20

[14]Which Countries Have Responded Best to Covid-19?, by Thomas Frieden, MD, Wall Street Journal, 1/2/21

[15]Florida Regulator threatens fining hospitals with Covid-19 vaccine mandates, by Tara Bannow, Modern Healthcare, 1/6/22

[16]A WHO official weighs in on Covid, vaccines and mistakes that were made, by Helen Branswell, STAT, 1/3/21

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Table 1. Confirmed Cases and Fatality Rates, OECD Countries as of 12/31/2021

Confirmed Cases (1)	Fatalities (1)	Fatality Rate %	38 OECD Countries (3)	Population (2)	Cases per 100,000	Fatalities per 100,000
14,120	51	0.4%	New Zealand	4,879,896	289.4	1.05
395,504	2,239	0.6%	Australia	25,910,156	1,526.4	8.64
27,059	37	0.1%	Iceland	344,504	7,854.5	10.74
630,838	5,563	0.9%	South Korea	51,334,293	1,228.9	10.84
1,732,296	18,389	1.1%	Japan	125,905,043	1,375.9	14.61
391,214	1,305	0.3%	Norway	5,843,535	6,694.8	22.33
260,292	1,564	0.6%	Finland	5,553,421	4,687.1	28.16
810,772	3,282	0.4%	Denmark	5,822,296	13,925.3	56.37
2,182,103	30,366	2.2%	Canada	38,246,108	5,705.4	79.40
1,383,932	8,243	0.1%	Israel	8,854,312	15,630.0	93.10
9,444,734	82,198	10.4%	Turkey	85,672,389	11,024.2	95.94
788,559	5,912	0.2%	Ireland	5,018,969	15,711.6	117.79
3,181,739	21,392	0.3%	Netherlands	17,190,607	18,508.6	124.44
7,173,718	112,033	19.6%	Germany	84,177,751	8,522.1	133.09
1,332,615	12,217	11.8%	Switzerland	8,741,810	15,244.2	139.75
570556	7353	0.6%	Costa Rica	5157718	11,062.2	142.56
103,766	915	0.1%	Luxembourg	640,960	16,189.2	142.75
241,408	1,932	0.1%	Estonia	1,327,849	18,180.4	145.50
1,314,784	15,310	0.2%	Sweden	10,192,160	12,900.0	150.21
1,278,619	13,733	0.1%	Austria	9,082,066	14,078.5	151.21
1,389,646	18,955	0.3%	Portugal	10,152,912	13,687.2	186.70
10,077,783	124,729	1.2%	France	65,486,233	15,389.2	190.47
6,294,745	89,405	1.4%	Spain	46,781,452	13,455.6	191.11
1,210,853	20,790	0.2%	Greece	10,348,049	11,701.3	200.91
1,806,494	39,115	2.2%	Chile	19,357,772	9,332.1	202.06
13,010,689	149,096	2.4%	United Kingdom	68,411,120	19,018.4	217.94
6,125,683	137,402	2.2%	Italy	60,330,865	10,153.5	227.75
3,969,686	299,285	7.5%	Mexico	130,926,674	3,032.0	228.59
2,089,657	28,308	10.2%	Belgium	11,663,899	17,915.6	242.70
276,674	4,570	0.1%	Latvia	1,855,470	14,911.3	246.30
54,479,594	**825,311**	**1.5%**	**United States**	**333,865,970**	16,317.8	**247.20**
5,147,039	129,901	2.5%	Colombia	51,681,176	9,959.2	251.35
4,108,215	97,054	2.4%	Poland	37,785,440	10,872.5	256.86
464,048	5,589	1.1%	Slovenia	2,108,977	22,003.5	265.01
519,597	7,387	1.4%	Lithuania	2,666,316	19,487.5	277.05
1,371,082	16,635	0.7%	Slovak Republic	5,463,567	25,095.0	304.47
2,475,729	36,129	1.5%	Czech Republic	10,738,133	23,055.5	336.46
1,265,415	39,186	3.1%	Hungary	9,624,216	13,148.2	407.16
149,341,257	2,412,881	1.6%	Total OECD	1,379,144,084	10,828.5	175.0

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1. Johns Hopkins Coronavirus Resource Center
2. Organisation for Economic Co-operation and Development, World Bank
3. Costa Rica became the OECD's 38th member nation during 2021

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Too Important to Fail Leadership Lessons for Nonprofits

Toni Pergolin

by Toni Pergolin

Nonprofit organizations play an increasingly important role in today's world by providing critical services to those in need. And yet many of them are on the edge of financial collapse. Even before the pandemic, providers were struggling to maintain services and keep standards high.

But circumstances have worsened by nearly every metric.

Many disability service providers are in crisis, with a majority reporting that they're shutting down programs, turning away new referrals and struggling to maintain standards. A survey recently conducted by the American Network of Community Options and Resources (ANCOR) of 449 disability service providers, showed the current state of the industry is bleak.

Of those surveyed, 58% of providers said they're discontinuing programs or services, 77% are turning away new referrals, 84% are delaying the launch of new offerings and 81% said they are struggling to achieve quality standards. Worse yet, 40% of providers said they're seeing higher frequencies of reportable incidents.

A report conducted with SeaChange Capital Partners and GuideStar titled, "The Financial Health of the United States Nonprofit Sector" found:

- 7-8% of nonprofits in the US are technically insolvent with liabilities exceeding assets
- 30% face potential liquidity issues with minimal cash reserves and/or short-term assets less than short-term liabilities
- 30% of US nonprofits have lost money over the last three years
- ~50% have less than one month of operating reserves

Today, workforce shortages are at the root of most of the problems disability service providers are experiencing, according to the ANCOR report. The industry has long struggled to attract and retain direct support professionals, but that situation has gotten much worse. Nearly 93% of providers surveyed said that "industries that previously paid comparable wages now pay employees more than my organization can afford to pay" while 86.2% said that the pay for direct support professionals is less than what people can receive from unemployment and other government safety net programs. And there's not much that providers can do about the situation since their pay rates are largely determined by the reimbursement they receive from Medicaid.

With all this in mind, what can we do to balance mission and margin? We need to focus on fulfilling our important missions every day while at the same time ensuring our long term sustainability.

In my book, **Too Important to Fail, Leadership Lessons for Nonprofits,** I share my own personal experience at a 138 year-old nonprofit. I joined the organization as Chief Financial Officer, only to learn the nonprofit was on the edge of bankruptcy. I tell the story of how I was able to take the organization from such a fragile state to financial stability -- doubling its size over the next decade, and then building a $75 million state-of-the-art campus to position ourselves for sustainability for years to come. This turnaround required a great deal of focus, discipline, teamwork and patience as we took step after step, continually monitoring our indicators, and waited to see the results slowly begin to turn positive.

Fifteen percent of nonprofits fail every year for many reasons. As leaders of organizations that provide vital community services, the following are worthy of serious consideration:

- Do we have strong leadership with business acumen?
- Are we prepared to survive inevitable crises?
- Do we have the strength and support we need at the board level?

Strong leadership and business acumen is critical. It is important for executives to remember that "nonprofit" is just a tax status, and that they have to run a business like anyone else. Leaders need to demand accountability across the organization.

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Everyone must understand the impact of their decisions on the financials. Discipline around no margin - no mission, investing in growth, and understanding the funding models is critical to sustainability.

It is not a matter of whether a crisis will ever happen, it's when a crisis will happen and so preparation is key. Most nonprofits are not prepared to survive a crisis, as they are just trying to survive day to day. Preparation in terms of cash reserves, technology, staffing, leadership and basically planning for the worst case, will help you to manage the crisis and keep the business moving forward.

Nonprofit leaders should build a board with the right people and expertise for what the organization needs at any given time -- whether it be financial, technology, real estate, mergers and acquisition among others. Most nonprofit board members are well intentioned and passionate about the mission, which is important. But members of a board responsible for vital services, must also have business acumen and financial savvy. They must provide fiscal oversight and be able to challenge management to come up with the right strategy for the future, while also supporting relationship-building and fundraising efforts.

These are very challenging times for everyone these days, and greater focus and accountability is required of all leaders to make it through. These leadership lessons will help your nonprofit overcome the day to day difficulties and survive.

About the Author

Toni Pergolin is the President and CEO of Bancroft and has served in that position for over 15 years. Under her leadership, Bancroft, a 138 year old nonprofit and one of the largest human services providers in New Jersey and the Greater Philadelphia region, has expanded its services and now provides extensive programs for people with intellectual and developmental disabilities, autism, and those in need of neurological rehabilitation.

Toni is actively involved in the community, and welcomes opportunities to help others with important missions. She has extensive board experience, including Fulton Bank and the Chamber of Commerce of Southern New Jersey -- serving on the boards of seven organizations -- both public and nonprofit - over the past decade. Additionally, she is currently the Chairwoman of Peirce College Board, and has just recently been appointed to the Inspira Health Board of Trustees. She also serves as a member of Dean Adya's Leadership Council at the Rutgers School of Business - Camden and is on the Advisory Board of SyndesiTech.

Toni is an author, with her new book ***Too Important to Fail: Leadership Lessons for Nonprofits,*** *now available on Amazon. The book describes her extraordinary story of how Bancroft went from operating on the edge of bankruptcy to doubling its size and building a state of the art campus for those Bancroft serves today and in the future.*

Don't miss Toni as Keynote Speaker at the upcoming NJ HFMA Women's Educational Event on April 27th, 2022!

•Certification Corner•

HFMA Has a New Certification: Certified Specialist Payment & Reimbursement (CSPR)

HFMA has launched the new Certified Specialist Payment & Reimbursement (CSPR) certification program. Those who earn this certification will have demonstrated specialist-level knowledge of the managed care environment, payment rates, benefit coordination, reimbursement models, cost-control incentives, legislative changes, and more. The content is somewhat different to the Certified Specialist Managed Care (CSMC) program, contains some clarifications, updated references throughout, new interactions, and new sections to include information on Transparency and The No Surprises Act (NSA).

This new CSPR program replaces the Certified Specialist Managed Care (CSMC), but access to CSMC does not go away for current enrollees. As a current participant in the CSMC certification program - enrollees may access and finish the CSMC program in their eLearning account.

As a reminder, HFMA offers the following certification:

- **Certified Revenue Cycle Representative - CRCR (2021)**
- **Certified Specialist Accounting and Finance (CSAF)**
- **Certified Specialist Physician Practice Management (CSPPM)**
- **Certified Specialist Business Intelligence (CSBI)**
- **Operational Excellence Exam - Module II of CHFP**

All certification programs are available online, 24/7, and certification, certification maintenance and digital badging are all included in HFMA membership.

For additional information please contact inquiry@hfma.org or arazanica@njha.com.

A Substantive Reimbursement Requirement for Medicare DSH Calculations

Michael Newell

by Michael Newell

According to the Centers for Medicare & Medicaid Services' (CMS) 2016 Outpatient Prospective Payment System (OPPS) Final Rule, for hospitals to potentially qualify for Medicare reimbursement related to any given issue, they must first make a cost report claim for the reimbursement.

Alternatively, if the provider feels the reimbursement associated with a specific item doesn't adhere to current Medicare policy, they must file the cost report under protest. This regulation applies to cost reports starting on and after January 1, 2016.

Additionally, CMS has instructed its Medicare Administrative Contractors (MACs) to accept one amended cost report for the purpose of reporting disproportionate share hospital (DSH) days within 12 months of the initial cost report filing.

While the regulations aren't new, many organizations struggle to complete them correctly. Certain conditions apply, as discussed below, but hospitals have an avenue to help verify days that couldn't have been identified at initial cost report filing will be addressed at a later date.

Background

Introduced in the fiscal year (FY) 2015 Inpatient Prospective Payment System (IPPS) Proposed Rule, and then adopted in the 2016 OPPS Final Rule, CMS incorporated a concept into the regulations that was initially introduced by the Provider Reimbursement Review Board (PRRB) Rules in 2008.

The PRRB, from a jurisdiction perspective, had been requiring this same treatment for cost reports going back to those starting on and after December 1, 2008. Then, the 2016 OPPS rule provided a shift from board rules surrounding jurisdiction over an issue to regulations governing cost report payment to highlight the importance of this matter.

CMS cited several reasons surrounding this adoption, including advancing the "interests of administrative finality and efficiency," claiming that MACs would have "an opportunity to correct any misconceptions that the provider may have had" concerning items filed under protest. In addition, CMS asserted this adoption would "enhance CMS' ability to accurately estimate the program's potential liabilities."

Medicare DSH and Medicaid Eligible Days

One item of good news is CMS has clearly acknowledged one area where it may not be possible for providers to claim the appropriate cost at the time of the initial cost report filing.

Specifically, they noted that the documentation of all Medicaid eligible patients claimed in the Medicare Disproportionate Share Hospital (DSH) calculation may not be available due to various items outside of the provider's control. In these instances, CMS states providers will continue to have the opportunity to submit amended cost reports, and the MACs will be required to accept them.

Many hospitals have material changes when retrospectively reviewing Medicaid-eligible days. The additional Medicaid eligible days that can't be documented at the time of filing averages 6.6%.

Timeline to Amend

CMS has instructed MACs to accept "one amended cost report submitted within a 12-month period after the hospital's cost report due date, solely for the specific purpose of revising Medicaid eligible patient days in order to calculate DSH payments after a hospital receives updated Medicaid eligible patient days from the state." See page 266 of the 2016 OPPS rule for details.

Parameters for Amending

Echoing the Medicare DSH appeal requirements set forth in PRRB Alert 10, CMS has placed strict parameters around amending a cost report for additional Medicaid eligible days, and it's not as easy as it may sound. Specifically, the provider must do all of the following:

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- Identify the number of additional Medicaid eligible days being sought in the amendment
- Describe the process used to identify the days claimed in the initial filing
- Explain why the additional Medicaid days couldn't be verified at the time of the initial filing

Challenges Hospitals Face in Meeting the Parameters

These requirements pose significant challenges for providers; they require in-depth record keeping and processes to support a hospital's claim for additional Medicaid eligible days that couldn't have been claimed in the initial cost report filing. Many healthcare providers aren't prepared to provide that level of detail, the eligibility verification process descriptions, or an explanation of why Medicaid days couldn't be claimed at the time of the initial cost report filing.

For hospitals that didn't include a state match when preparing the initial Medicare DSH data – or those that use multiple processes, such as utilizing an internal process for the initial cost report filing and then a subsequent review by the hospital or an outside firm – proving the additional days found on a secondary run that couldn't have been claimed in the initial filing is challenging.

Additionally, the hospital will have to defend its process for completeness and thoroughness and prove it captured all the available days at initial cost report filing. This may prove difficult if there are different processes or different players involved in the two looks at DSH-eligible days.

Consequences

It's expected that MACs will strictly enforce these parameters, and it's clear that simply filing an amended cost report with additional Medicaid-eligible days without evidence of a robust Medicare DSH reimbursement process could be subject to rejection by the MAC.

To learn more, ask about our Medicare DSH checklist.

Considerations for Hospitals

With this substantive reimbursement requirement firmly in place, hospitals must have a consistent process for claiming costs for Medicare DSH to fully address the filing of all allowable costs in the initial cost report and protest items. This process will also be necessary when filing timely cost report amendments.

As a result of the requirements, hospitals should:

- Evaluate if in-house or vendor's Medicare DSH processes meet these requirements
- Verify the reimbursement team has the necessary systems, resources, and protocols in place

It's also recommended hospitals put their best efforts forward when compiling initial cost report patient detail to help ensure it's complete and compliant.

Further, hospitals should verify their staff or vendor is monitoring the 12-month deadline. The 12-month window generally ends around the next filing of the cost report, therefore it's often a busy time, and this deadline could get missed.

The absence of a cohesive, consistent process is likely to result in hurdles and obstacles on the way to the successful settlement of amended cost report filings, or unfortunately, the denial of the amendment. If providers don't adhere to the timeline and requirements set forth in this regulation, initial payment determinations, an amended cost report, and any additional DSH reimbursement could fall to the wayside.

About the Author

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

Considerations for COVID-19 Accelerated and Advance Payment (CAAP) Recoupments

Mandy Mori

by Mandy Mori and Denise Stark

Denise Stark

The Medicare Accelerated and Advance Payments (AAP) program assists certain types of providers with advances on future claims to help with funding due to a disruption in claims submission or processing.

With the passage of the Coronavirus Aid, Relief and Economic Security (CARES) Act, the Centers for Medicare and Medicaid Services (CMS) expanded the existing AAP program on March 28, 2020, to include a broader group of Medicare Part A providers and Part B suppliers. Changes also included added benefits as well as extended repayment terms.

Now known as COVID-19 Accelerated and Advance Payments (CAAP), the revised program aims to increase cash flow to health care providers, physicians, and suppliers during the COVID-19 public health emergency (PHE). These advances are recouped on remittances by Medicare Administrative Contractors (MACs)

Depending on when providers received the payments, they already experienced or will experience recoupments on their remittances. The following is an overview of key program details and items providers should consider with regards to the recoupments.

AAP Background

The Omnibus Budget Reconciliation Act of 1986 on October 21, 1986 first authorized the AAP program to provide so-called accelerated payments to Medicare Part A, or hospital, providers.

The program intended to expeditiously replace lost provider revenue in times of national emergencies or disasters and enable providers to remain solvent. The program extended in 1996 to include an advance payment program to Part B providers, such as doctors and other outpatient care.

The coalescence of both accelerated and advance payments sought to quickly sustain the health care ecosystem through recovery. These payments may be forgiven in part or repaid over time as health care utilization resumes.

Who Is Eligible for COVID-19 Accelerated and Advance Payments?

Per CMS, to qualify for CAAP, the provider or supplier must:

- Have billed Medicare for claims within 180 days immediately prior to the date of signature on the provider's or supplier's request form
- Not be in bankruptcy
- Not be under active medical review or program integrity investigation
- Not have any outstanding delinquent Medicare overpayments

Distribution of Payments

As of December 9, 2020, CMS reported approximately $98.8 billion dollars in accelerated payments were distributed to Part A providers and another $8.5 billion dollars advance payments to Part B suppliers.

Payments were distributed to providers as requests were processed. Applications were accepted by CMS until October 8, 2020.

Recoupment Process for Payments

Unlike Provider Relief Funds, these loans are repayable to the Medicare Trust fund.

Providers can repay the loan by contacting their MAC directly. If repaid in full, the following repayment terms don't apply.

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Recoupment Schedule

Any outstanding loans will be recouped by the MACs over 29 months. They will appear as takebacks at the provider level balance in remittances from the date of the disbursement. The recoupment schedule is as follows:

- One year from date of disbursement, no recoupment applied
- Next 11 months, recoupment at 25%
- Next 6 months, recoupment at 50%
- After 29 months from disbursement, recoupment at 100% plus interest

Interest Rate

After six months recoupment at 50%, a demand letter will be issued for any remaining unpaid balances to be repaid within 30 days—with 4% interest levied from the date of the demand letter.

Recoupment will occur at 100% if a provider doesn't repay within 30 days. This means that all Medicare payments will be withheld until the entire balance plus interest is paid in full.

Mergers, Acquisitions, and Change in Ownership

For many providers, recoupments already started.

Providers should be cognizant that mergers, acquisitions, or change in ownership during and after the PHE may increase their recoupment liability if the acquired provider also received CAAP funds.

Key Thoughts and Considerations for Providers

As of May 31, 2021, CMS reported approximately $81 billion from Part A providers and $5.9 billion from Part B providers or suppliers remain unpaid.

Providers should consider the following questions when thinking through CAAP recoupment impact:

- Will I be able to repay the entire amount of the loan before recoupment begins?
- What effect will this have on my cash flow and for how long?
- How can I prepare now for Medicare cash shortfalls over the recoupment period?
- Our organization didn't take any accelerated or advanced payments, but acquired organizations, groups, or providers who received distributions. How will this affect my organization?
- How do I properly record the transactions for recoupment?
- How do I track various recoupments for my organization and predict the effects on cash flow?
- Will my Medicare fee-for-service (FFS) patient volume remaining constant to support timely repayment?
- What if I still owe a balance at the end of the 50% recoupment period? What are my options if I receive a demand letter and can't repay the balance?
- What is the impact if I already owe Medicare and am on an installment plan for non-CAAP monies?
- What if I am understaffed or have finance or revenue cycle staff laid off as a result of the COVID-19 PHE?

Tips to Help Providers Mitigate the Effects of CAAP Recoupments

The following tips can help prepare for the impact of CAAP recoupments:

- Estimate Medicare cash shortfalls in the upcoming months and trend the length of time to repay advance payments
- Develop solutions to address cash flow shortages by targeted cash acceleration from other payors
- Develop and implement an action plan to handle recoupment offsets and reconciliation
- Redeploy resources and repurpose and train staff to facilitate improved revenue cycle operations
- Review and develop options for repayment at the end of the recoupment period

About the authors

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Top items to consider when preparing your Medicare Cost Report

Josh Weissenborn

Andrew Kinnaman

by Josh Weissenborn and Andrew Kinnaman

Beyond being a compulsory filing, Medicare Cost Reports are an important component of how hospitals are reimbursed from the program. Following are some of the top items to examine as you embark on preparing your next cost report. Do not view these items as an exhaustive list of everything you'll need to do when preparing a cost report. Rather, this represents a starting point to ensure you focus on key areas. As with any complex filing, you should seek the counsel of firm experienced in the nuances of this reporting if you require additional expertise.

Cost report common review points by worksheet

Worksheet S-2, Part I & II
Hospital Identification Data

1. Complete the informational Worksheet S-2. Answer questions on this worksheet by referencing the prior year worksheet and current year management inquiry.
2. Look for changes in the Hospital and Hospital Based Components, and review payment methodologies of each component.
3. Review all answers in the questionnaire to ensure there is no impact to the settlement calculations (IME/GME, DSH, NAHE, etc.).

Worksheet S-3 Part I
Statistical Data

A. Beds & Bed Days Available

1. Are the number of beds based on licensed or available beds? If based on available - is there adequate supporting documentation?
2. Have there been any changes to beds during the year (i.e., renovations, long-term closings, etc.)?

B. Patient Census

1. Does the patient census data (days and discharges) for each column reported on Worksheet S-3, Part I, reconcile to the hospital's internal census count and/or paid claims data?
2. Are Observation bed days properly excluded from total patient days?
3. Are Labor/Delivery Room days properly accounted for and reported?

C. Full Time Equivalents (FTE)

1. Is the accumulation of FTEs for interns and residents accurate and comparable to the prior year?

Worksheet S-3 Parts II and III - Wage Index

1. Do all salary reclassifications and adjustments flow correctly to S-3 Pt II? Are the associated hours also properly reclassed and/or adjusted?
2. Are on-call hours, hours associated with bonuses/incentives, etc. excluded from reported paid hours?

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3 Are wage-related costs properly identified and reported including amounts for excluded areas, physicians, interns and residents, etc.?

4 Are contract labor dollars and hours reported and supported by detailed documentation?

5 Is the average hourly rate computed on Worksheet S-3, Part III reasonable? If the rate has decreased from the prior year, has the hospital reviewed the accumulation of data and documented any extraordinary circumstances?

Worksheet S-10 - Uncompensated and indigent care data

1 Verify Write-offs adhere to the provider's documented Bad Debt and Charity Policy.

2 Ensure proper reporting of Insured vs. Uninsured Charity patients.

3 Reconcile write-offs using transaction detail to GL.

Worksheet A - Trial Balance of Expenses

1 Do the total departmental expenses reported on Worksheet A, column 3 reconcile to the general ledger trial balance and the audited financial statements?

2 Are the departmental expense groupings consistent with the prior year groupings including changes proposed by the Intermediary?

3 Are there any newly established cost centers during the current year? If so, how are these departments being combined in the grouping schedule?

4 Are the departmental expenses reported on Worksheet A, column 3 reasonable compared to the prior year?

Worksheet A-6 - Reclassification of Expenses

1 Adhere to the matching principle by reclassifying Expenses using appropriate methodology to follow Revenue reclassifications.

2 Compare reclassifications to Prior Year and ensure amounts and nature of the reclass seems appropriate.

3 Review any reclassification that results in a negative cost center amount reported on Worksheet A Column 7.

4 For any capital cost reclassifications, ensure the appropriate Worksheet A-7 line is included.

Worksheet A-8 - Adjustments to Expenses

1 Reconcile other operating and non-operating revenues and expenses reported on the Audited Financial Statements to those offset on A-8.

2 Identify and offset non-allowable costs (e.g. Lobbying, non-patient care related travel, marketing costs, etc.).

3 Is investment income offset apportioned to all cost centers that include interest expense?

4 Does the interest income offset on Worksheet A-8 exceed the interest expense claimed on Worksheet A? If so, then be sure to offset interest income only to extent of interest expense.

Worksheet A-8-1 - Related Party Costs

1 Review last audited hospital and Home Office cost reports for significant adjustments. Eliminate proxy amounts and substitute the properly allocated Home Office costs from the most recently filed Home Office cost report.

2 Are all related parties under common ownership or control disclosed on Worksheet A-8-1?

3 Prepare a prior year comparative workpaper summary of related party costs. Reconcile and document the material variances between years.

4 Were all Home Office expenses allocated to the hospital and included in Worksheet A expenses reported on Worksheet A-8-1, Col. 5?

5 Are home office cost allocations reconciled to the home office cost statement and reported to the proper department on Worksheet A-8-1?

Worksheet A-8-2 - Provider Based Physicians

1 Review or prepare schedule of HBP fees paid during the year. This schedule should indicate physician name and specialty, purpose of payments (i.e., Part A and/or Part B services provided and percentages of time based on time logs), and the general ledger account numbers for expense amount. Review contracts for agreement with amount paid and allocation agreement.

2 Does the hospital maintain appropriate time records to support the allocation of physiciancosts between the administrative and professional components? Time studies should be reviewed for proper documentation of Part A and Part B.

Note: Time studies are not required for contracts that are 100% Part A. However, contracts for both types of services should be supported by time studies that document Part A, Part B and non-patient care time spent by physician.

3 Identify related payroll taxes and benefits to include in total compensation.

Note: Employment related taxes are includable in total as part of administration cost.

4 Identify and physician billing costs and ensure that costs have been properly included as compensation on Worksheet A-8-2 or removed via Worksheet A-8.

Worksheet B-1 - Statistical Basis for Cost Allocation

1 Has the hospital changed any allocation bases from that used in the prior cost reporting year? If so, did the MAC previously provide approval for the change?
2 Are there any significant fluctuations in the statistics that need to be investigated?
3 Do the non-reimbursable cost centers receive appropriate overhead allocations?
4 Do the statistics reported on Worksheet B-1 properly account for any reclasses of expenses?

Worksheet C - Total Patient Revenues

1 Gross Revenue per general revenue should be reconciled to audited financial statements prior to any reclassifications or adjustments.
2 Verify groupings on Worksheet C are consistent with expense groupings reported on W/S A.
3 Identify patient revenues that may be necessary to excluded from Worksheet C, including professional revenues and self-insured employee health plan revenues.
4 Identify patient revenues that may be necessary for reclassification to ensure the principle of matching expense and revenues. Most common reclassifications include:

-Medical Supply, Implant, Drugs, Observation Care or any other applicable to the operations of the hospital (i.e., Family Birth Center – split for Obstetrics, Labor & Delivery, and Nursery)

5 Review cost to charge ratios for reasonableness and prior year. Prepare and analysis for those cost report line numbers that are not reasonable.

Medicare Settlement Data

1 Perform an analysis to support the mapping of PSR amount to the cost report, including the following:
   a) Verify that PSR was run utilizing proper reporting period splits for the cost report period.
   b) Review the PSR and cost report for special payment amounts, such as, new technology, HAC adjustment, etc.
   c) Verify that all net reimbursement amounts have been reported on Worksheet E-1. For facilities with an approved Medical Education program, this should include Net Reimbursement on report type 118.
2 Verify all Medicare interim payments and lump-sums have been identified and properly reported on Worksheet E-1.
   a) Request from the MAC or through correspondence the lump-sums or pass-thru payments applicable for all provider types.
   b) Verify that lump sums to the provider are on line 3.01 and subscripts and payments to the program are on line 3.50 and subscripts.
3 Review Worksheet D-3 and D, Part V charge data to ensure correct grouping and mapping to Medicare cost report lines.
4 Medicare revenue reclassifications should be applied consistent with Worksheet C reclassifications (refer to Worksheet C section above).
5 Verify total charges per the PSR agree to the cost report. If not, prepare an analysis as to the difference.
6 If using Medicare Revenue and Usage to allocate PSR charges verify the reasonableness of the charges by provider type to the Medicare PSR by provider type.
7 Compare Settlement between years with special attention to non PSR or payment settlement areas, including the following:
   a) Medicare Bad Debts

continued on page 44

continued from page 43

b) Medical Education (IME/GME)
   i. Verify resident cap Inputs on Worksheets E, Part A and E-4 (if applicable Worksheets E-3, Part II & III).
   ii. Verify current year resident FTE to source and IRIS files.
   iii. Verify the prior year and penultimate year FTE counts and consider any changes based on amended or settled cost reports.
   iv. Verify the prior year intern to bed ratio on Worksheet E, Part A.
   v. Update to the current per resident amount on Worksheet E-4.
   vi. Compare Worksheet E, Part A bed days available between years for reasonableness.
   vii. Verify that Managed Care Simulated Payments are reported on Worksheet E, Part A.
   vii. Ensure the appropriate Medicare Advantage GME payment reduction is reported on Worksheet E-4.

c) Disproportionate Share Hospital Adjustment
   i. Verify the responses on Worksheet S-2, Part I, including the input of Medicaid days on line 24 and 25.
   ii. Verify and document the SSI% on Worksheet E, Part A (hospital) and E-3, Part III (IRF).

d) Nursing and Allied Health Managed Care Payment - Prepare the offline calculation if applicable (Refer to CMS Change Request 11642, dated August 21, 2020).

e) HAC Program Reduction Adjustment - If subject to HAC, complete Worksheet E, Part A, Exhibit 5.

Worksheet L - Capital

1 Reconcile capital amounts reported on W/S L to the PS&R?

2 If the hospital qualifies for DSH, have capital DSH payments been properly recalculated based on the filed cost reporting data?

3 If the hospital qualifies for IME, have capital IME payments been properly recalculated based on the filed cost reporting data?

About the Author

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Save the Date….

Annual NJ HFMA Golf Outing

Thursday, May 12th, 2022, 1PM shotgun start

Mercer Oaks
West Windsor Township, NJ

Prizes and raffles!

More Information Available Soon!