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Winter 2021 • vol 67 • num 2

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- Update from John Dalton on the US response
- Navigating COVID Workplace changes

Medicare cost report updates

Institute flashback

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DEADLINE FOR SUBMISSION OF MATERIAL

Issue Date	Submission Deadline
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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.

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

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

Stacey L. Medeiros

Happy New Year! This new year was greatly anticipated after the hardships of 2020. Here's hoping 2021 brings a year of peace, prosperity and good health for all of our members.

Throughout much of 2020, we often wistfully thought of the "good old days" before the pandemic, where we could easily do certain things that perhaps we took for granted – the simple act of gathering with friends and family, attending events or traveling. In the spirit of reminiscing, we've decided to take a trip down memory lane in this issue of the *FOCUS*. Our post-Institute winter issue typically contains a recap of the Institute with photos. Since our event was virtual this year, we did not have as much to share for this piece. In its place we hope you enjoy a collection of photos and articles from past Annual Institute's over the past couple of decades. Special thanks to Laura Hess for putting together this montage from her vast collection of NJ HFMA files and data.

As we turn into 2021, we have renewed hope through the rollout of the COVID19 vaccines that eventually sometime this year a certain level of normalcy will return and we will be able to meet again in person safely. One of the first live events we are planning is our annual Golf Outing, which will be held Thursday, May 6. We are optimistic this event will be able to happen, since it is outdoors and allows for social distancing. For the first time, our Golf Outing will be held at Mercer Oaks in West Windsor, New Jersey. The centralized location will hopefully encourage more of our members to participate. In addition, the move to Mercer Oaks allows us to be more conscious of costs to the chapter and our membership in the continued times of stress on budgets. Mark your calendars to join us, more details on registration and sponsorship will be available shortly.

Until then, we continue to plan a full slate of virtual offerings for our members. The Patient Financial Services and Patient Access committees kicked off 2021 with a successful virtual joint session January 11 and 12. Other upcoming virtual education events include our Medicare Cost Report half-day session on February 4 and monthly webinars in collaboration with other chapters in HFMA Region 3. Our networking committee is continuing to plan virtual happy hours, with the first one of 2021 scheduled for February 10. And, in follow up to the success of our virtual wine tasting in December, the committee has planned an exciting cooking demonstration for March 24. Our guest chef will be New Jersey's own Joseph Gramaglia from Sally G's restaurant in Warren and a recent winner of Food Network's Chopped. Aergo Solutions has generously offered to sponsor this event, which will be offered free of charge for members. Watch your email and our website www.hfmanj.org for more details.

Regards,
Stacey L. Medeiros

From The Editor . . .

Scott Besler

As we begin 2021, we hope that this issue finds you, your family and friends healthy and happy. We trust that you found time to enjoy the holiday season and "sharpen your saw" for the upcoming year – a year that will give us each an opportunity to continue to use the skills that we have developed and strengthened throughout this pandemic.

Thank you to all of the members that have contributed to this, as well as previous issues. As we all know, deadlines may be pushed back but still loom on the horizon. Special appreciation is extended to Brian Herdman who works tirelessly with the *FOCUS* and Communication committee to ensure the content is useful to our readers. Brian, along with the other "unsung" members of the committee, continue to make the distribution of these issues part of their ever-expanding "to do" lists.

This year's first issue contains Laura Hess' article where she shares the various experiences of industry leaders in managing through COVID. Maja M. Obradovic and Jemi Goulian Lucey, discuss the potential issues for employees and employers regarding COVID-19 vaccinations. Domenic Segalla's article mentions the Provider Relief Funds and what is next for providers as they navigate through the FAQs that seem to be updated weekly (or at least bi-weekly). New Medicare cost report changes for the 2021 year are discussed – new exhibits that are statistical in form and many know that these types of schedules can lead to additional requirements that can affect future years' reimbursement. Mike Newell educates us on Medicare bad debts, and an additional article by Amy Duncan outlines what auditors require when reviewing these accounts. We know the reimbursement is only cents on the dollar. However, these accounts can have a great impact. Former Chapter President, Scott Mariani discusses the latest on employment tax reporting and his recommendations for compliance. Finally, John Dalton, continues his series on how the U.S. is doing in part 3 of The COVID-19 Pandemic – which is a must-read sequel.

In closing, please mark your calendars to join us for a day on the links at the annual golf outing to be held, on May 6th, 2021 at Mercer Oaks Golf Course in West Windsor. More details about this wonderful event will follow in the coming weeks.

Best to you during 2021. We look forward to seeing you at upcoming chapter events.

Thank you.

Please stay well during this challenging time!

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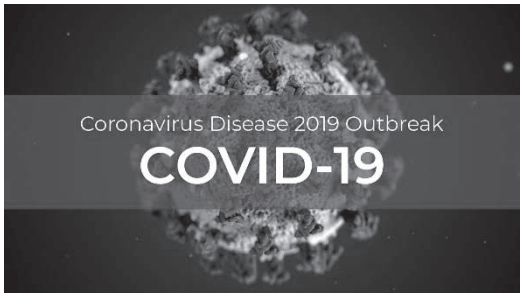
The COVID-19 Pandemic – How is the U.S. doing? Part 3

John Dalton

by John Dalton, FHFMA



The short answer – still not well, and with some added company.

Part 1, written May 1st for the Spring issue, compared America's pandemic performance with the other member countries of the Organisation for Economic Co-operation and Development (OECD) as of April 30[1]. With 61,931 deaths and a fatality rate of 19.4/100,000 residents, the U.S. ranked 29th among the 37 OECD members.

By Part 2, written September 21st for the Fall issue, the U.S. had slipped to 33rd place in the OECD, trailed only by Spain, Chile, the United Kingdom (UK) and Belgium[2]. November 30 finds the U.S. in a virtual dead heat with Mexico and Chile for 31st place, then trailed by the UK, Italy, Spain and Belgium (see Chart 1: Covid-19 Fatality Rates, 20 OECD Members, 11/30/20). Table 1 - Confirmed Cases and Fatality Rates, OECD Countries as of 11/30/2020 displays the underlying data. With more than 270,000 deaths and a fatality rate of 81.66/100,00, COVID-19 has wiped out the equivalent of the entire population of the author's Jersey City hometown.

New Zealand, South Korea, Japan and Australia continue to lead the OECD in controlling the coronavirus. Their successful approaches were described in Part 1 of this series. Within the U.S., states with the highest fatality rates continue to be those hit early (Louisiana, Connecticut, Massachusetts, New York and New Jersey), but others have begun to close the gap after the Sunbelt's summer surge (see Chart 2: Covid-19 Fatality Rates, 20 Selected States, 11/30/20). More recently, the Mountain and Plains states are experiencing an overwhelming surge following the annual Sturgis Motorcycle Rally[3]. That super spreader event drew nearly 500,000 to the small South Dakota town from August 7-16. Kaiser Family Foundation epidemiologist Josh Michaud said: "*Holding a half-million-person rally in the midst of a pandemic is emblematic of a nation as a whole that maybe isn't taking [the novel coronavirus] as seriously as we should.*"

Chart 1: Covid-19 Fatality Rates, 20 OECD Members, 11/30/20

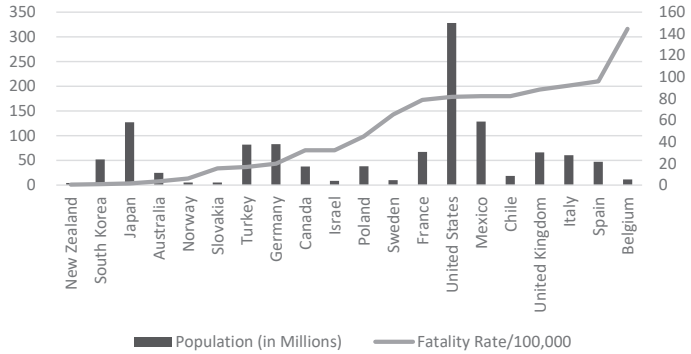


Chart 2: Covid-19 Fatality Rates, 20 Selected States, 11/30/20

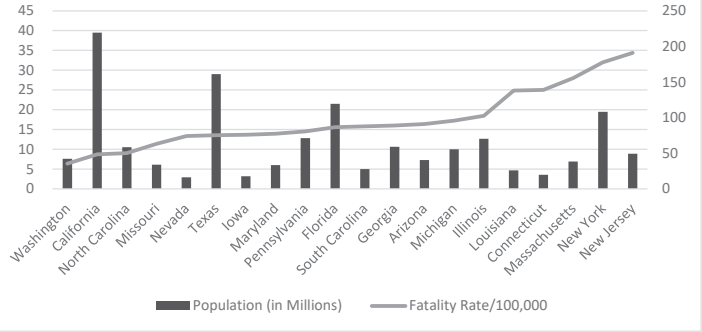
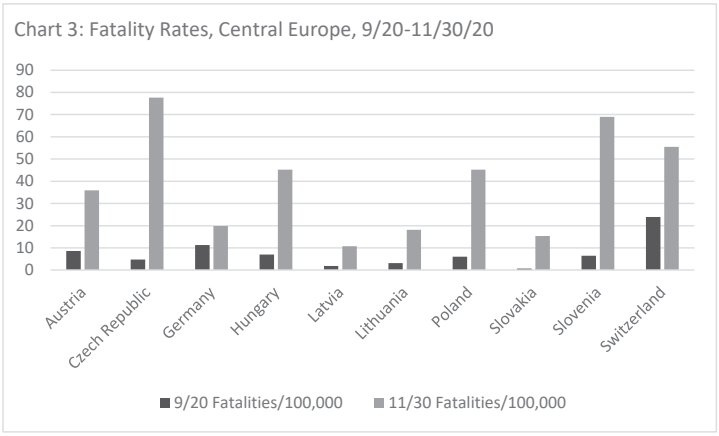


Table 1. Confirmed Cases and Fatality Rates, OECD Countries as of 11/30/2020

Confirmed Cases (1)	Fatalities (1)	Fatality Rate (%)	37 OECD Countries	Population (2)	Cases per 100,000	Fatalities per 100,000
2,056	25	1.2%	New Zealand	4,886,000	42.1	0.51
34,201	526	1.5%	South Korea	51,640,000	66.2	1.02
148,945	2,075	1.4%	Japan	127,298,000	117.0	1.63
27,904	908	3.3%	Australia	24,990,000	111.7	3.63
35,971	332	0.9%	Norway	5,368,000	670.1	6.18
24,912	399	1.6%	Finland	5,570,000	447.3	7.16
5,392	26	0.5%	Iceland	350,374	1,538.9	7.42
12,308	118	1.0%	Estonia	1,329,000	926.1	8.88
17,075	206	1.2%	Latvia	1,920,000	889.3	10.73
81,002	837	1.0%	Denmark	5,806,000	1,395.1	14.42
105,929	839	0.8%	Slovak Republic	5,450,000	1,943.7	15.39
638,487	13,746	2.2%	Turkey	82,000,000	778.6	16.76
61,325	506	0.8%	Lithuania	2,794,329	2,194.6	18.11
1,069,491	16,480	1.5%	Germany	83,020,000	1,288.2	19.85
105,271	2,406	2.3%	Greece	10,720,000	982.0	22.44
377,499	12,093	3.2%	Canada	37,600,000	1,004.0	32.16
336,160	2,864	0.9%	Israel	8,884,000	3,783.9	32.24
282,456	3,184	1.1%	Austria	8,859,000	3,188.4	35.94
72,544	2,053	2.8%	Ireland	4,904,000	1,479.3	41.86
298,061	4,505	1.5%	Portugal	10,280,000	2,899.4	43.82
990,811	17,150	1.7%	Poland	37,970,000	2,609.5	45.17
217,122	4,823	2.2%	Hungary	9,773,000	2,221.7	49.35
34,678	321	0.9%	Luxembourg	613,894	5,648.9	52.29
531,911	9,453	1.8%	Netherlands	17,280,000	3,078.2	54.70
327,072	4,753	1.5%	Switzerland	8,570,000	3,816.5	55.46
243,129	6,681	2.7%	Sweden	10,230,000	2,376.6	65.31
75,806	1,435	1.9%	Slovenia	2,081,000	3,642.8	68.96
1,308,376	36,584	2.8%	Colombia	49,650,000	2,635.2	73.68
521,132	8,273	1.6%	Czech Republic	10,650,000	4,893.3	77.68
2,274,579	52,816	2.3%	France	66,990,000	3,395.4	78.84
13,492,101	**267,600**	**2.0%**	**United States**	**327,700,000**	**4,117.2**	**81.66**
1,107,071	105,655	9.5%	Mexico	128,600,000	860.9	82.16
551,743	15,410	2.8%	Chile	18,730,000	2,945.8	82.27
1,633,652	58,545	3.6%	United Kingdom	66,270,000	2,465.1	88.34
1,601,554	55,576	3.5%	Italy	60,360,000	2,653.3	92.07
1,648,187	45,069	2.7%	Spain	46,940,000	3,511.3	96.01
576,599	16,547	2.9%	Belgium	11,460,000	5,031.4	144.39
30,872,512	770,819	2.5%	Total OECD	1,357,536,597	2,274.2	56.8

DATA SOURCES:

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



Second Surge in Central Europe

The eleven weeks from September 20 through November 30 witnessed the rapid rise of COVID-19's second surge, striking ten OECD members in Central Europe with a vengeance (see Chart 3: Fatality Rates, Central Europe, 9/20-11/30/20). Previously, Slovakia had the lowest fatality rate in the Western Hemisphere at 0.72/100,000 thanks to a March 16 national lockdown with universal compliance. Its fatality rate increased twentyfold to 14.67/100,000 by November 30. Likewise, the neighboring Czech Republic (Bohemia) experienced a fifteenfold increase from 4.71 to 77.68/100,000. Even Germany, which has maintained the lowest fatality among major Western democracies and canceled Oktoberfest, had a 75 percent increase in its fatality rate/100,000 from 11.81 to 19.85.

Clearly, COVID fatigue is both real and dangerous!

With more than 4 million confirmed cases during November, the U.S. is just weeks behind Central Europe's second surge as the country heads into a challenging winter. Dr. Robert Redfield, head of the CDC, warns that the pandemic will pose the country's grimmest public health crisis yet over the next few months, noting that the University of Washington's Institute for Health Metrics and Evaluation has projected the death toll could reach nearly 450,000 by March 1[4]. To place that amount in perspective, 415,399 American lives were lost during the 45 months of World War 2.

One of America's founding fathers, Thomas Paine said, "*These are the time that try men's souls.*"[5] However, there is a light at the end of the tunnel: three vaccines have completed Phase 3 clinical trials with a high degree of effectiveness, and two already have applied to the FDA for emergency use authorization.

The Light at the End of the Tunnel

On November 9, Pfizer and its partner, German drug maker BioNTechSE, announced that its COVID-19 vaccine may be 90% effective based on data from its phase 3 clinical trials[6]. This interim analysis, from an independent data monitoring board, looked at 94 infections recorded so far in a study that has enrolled nearly 44,000 people in the U.S. and five other countries. For the vaccine to be 90% effective, nearly all the infections must have occurred in placebo recipients. The Pfizer vaccine consists of genetic material called mRNA encased

Clearly, COVID fatigue is both real and dangerous!

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in tiny particles that shuttle it into our cells, then trains the immune system to recognize the spiked protein on the surface of the virus. Since it's not made with the coronavirus itself, there's no chance anyone could catch it from the shots.

One week later, Moderna announced that its experimental vaccine was 94.5% effective in preventing disease, according to an analysis of its clinical trial[7]. The Moderna study included 30,000 volunteers: half got two doses of the vaccine 28 days apart; half got two shots of a placebo on the same schedule. Of 95 instances of COVID-19 illness among the study participants, only five cases were in the vaccinated group. The Moderna vaccine also is based on mRNA, or messenger RNA.

The Moderna and Pfizer studies were conducted using slightly different protocols. To be counted as a COVID-19 case, participants in the Moderna study had to have at least two symptoms of disease in addition to a positive test for the virus. The Pfizer study required only one symptom. Also, Moderna waited 14 days following the second injection to begin counting cases; Pfizer's study started counting at seven days.

Pharmaceutical giant Pfizer's chief executive, Dr. Albert Bourla, had chosen from the start to keep Pfizer at arm's length from the government's crash effort, Operation Warp Speed, and declined federal research and development money[8]. Moderna, a much smaller biotech firm with 800 employees, received nearly $2.5 billion, teaming up with the National Institutes of Health's Vaccine Research Center on the scientific work in a successful partnership to develop, manufacture and sell its vaccine to the federal government. In a contest between David (Moderna) and Goliath (Pfizer), America won!

The encouraging late-stage trial results from Pfizer and Moderna have set a high bar for rival vaccines soon to follow[9]. Both use messenger RNA technology that instructs cells to make copies of the coronavirus spike protein stimulating the creation of protective antibodies. Pfizer's vaccine requires deep freeze storage (-94F) but can be kept at refrigerator temperatures for as much as five days. Moderna's vaccine can be safely stored in freezers at about 25F and is stable at refrigerator temperatures for 30 days, which should ease distribution. Both companies are seeking emergency-use authorization from the U.S. Food and Drug Administration with Pfizer's review scheduled for December 10 and Moderna's review one week later. It's unclear how long protection will last or how many will refuse to be vaccinated. Ramping up production and distributing the doses also pose challenges.

On 11/23, Astra-Zeneca announced that its vaccine developed in the UK with Oxford University can protect 70.4% of people from becoming ill and up to 90% if a lower first dose is used[10]. Chief Investigator Andrew Pollard, director of the Oxford Vaccine Group said, *"We think that by giving a smaller first dose that we're priming the immune system differently – we're setting it up better to respond."* The Astra-Zeneca vaccine uses a different technology than mRNA (it's a replication-deficient viral vector vaccine), is much less expensive, and requires only refrigerator storage[11]. The UK has preordered 100 million doses. Novovax, Johnson & Johnson and several others also have various COVID-19 vaccines in phase 3 clinical trials.

The development of three promising vaccines in so short a period is an incredible achievement. Production and distribution challenges remain, but this is an important first step.

Vaccine Rollout Plans

Experts have compared the logistical challenges of delivering vaccinations to hundreds of millions of Americans to the enormous efforts involved in gearing up industrial production during World War 2. Who should the vaccine be given to first? How will it be distributed and stored? Who will be allowed to administer injections? What records will be kept? All burning issues currently being addressed.

CDC
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On December 1, The CDC's Advisory Committee on Immunization Practices (ACIP) voted 13 to 1 to put health care providers (21 million) and long-term care residents (3 million) at the top of the vaccine priority list[12]. The ACIP has been meeting at least monthly since the spring, using mathematical models and ethical frameworks to try to determine how to best use scarce supplies of vaccine when the national vaccination effort begins. Next up are likely to be roughly 85 million "essential workers," followed by everyone over 65 and adults with medical conditions that put them at high risk of coronavirus infection, such as diabetes or obesity. However, state officials will also be responsible for ultimately deciding which residents are the first to get the vaccines.

A division of the Department of Homeland Security has compiled a list of essential workers that includes teachers and others who work in schools, emergency responders, police officers, grocery workers, corrections officers, public transit workers and others whose jobs make it hard or impossible to work from home. Pfizer and Moderna estimate that they will have enough to vaccinate 22.5 million Americans with the required two doses by year's end.

Moncef Slaoui, Operation Warp Speed's chief advisor,

predicted that 100 million Americans would be immunized by the end of February[13]. Outlining an ambitious timeline, Slaoui expects 20 million Americans to be vaccinated by year end, followed by 30 million in January and another 50 million in February. By then, "*we will have potentially immunized 100 million people, which is really more or less the size of the significant at-risk population: the elderly, the healthcare workers, the first-line workers, people with comorbidities,*" Slaoui said.

A recent research study conducted by Yale and Harvard examined vaccine efficacy and found that found that factors related to implementation will contribute more to the success of vaccination programs than a vaccine's efficacy as determined in clinical trials[14.] They learned that the benefits of a vaccine will decline if manufacturing or deployment delays, significant concerns in the public about getting vaccinated or greater epidemic severity develops. They found that there is an urgent need for health officials to continue and expand efforts to promote public confidence in COVID-19 vaccines, and to encourage continued adherence to other mitigation approaches, even after a vaccine becomes available.

When interviewed by the New York Times about the study, Dr. A. David Paltiel, professor at the Yale School of Public Health, said "*Vaccines don't save lives. Vaccination programs save lives.*"[15] His study team concluded that to reduce the pandemic's infections, hospitalizations and deaths, a successful vaccine rollout was just as important as the vaccine's efficacy. Dr. Paltiel is concerned that the U.S. has not done enough to prepare for successful distribution of the vaccine in the months to come. This study makes it clear that mitigation measures along with a successful rollout of approved vaccines and public commitment to getting vaccinated are all important to controlling COVID-19.

Opposition is expected from COVID deniers and anti-vaxxers. However, if the rollout is successful, experts expect that the U.S. could return to a new normal by late April/early May by which time millions of the general public will have been vaccinated. The new normal likely will be quite different - social distancing and mask wearing in public are likely to be universal.

References

[1]The COVID-19 Pandemic – How is the U.S. doing? by John Dalton, FHFMA, Garden State Focus, Spring 2020, Vol. 66, Num 2

[2]The COVID-19 Pandemic – How is the U.S. doing? Part 2 by John Dalton, FHFMA, Garden State Focus, Fall 2020, Vol. 66, Num 3

[3]How the Sturgis Motorcycle Rally may have spread the coronavirus across the Upper Midwest, by Brittany Shammas and Lena H. Sun, Washington Post, 10/17/20

[4]CDC chief warns Americans face 'rough' winter from COVID-19 surge, by Steve Gorman, Daniel Trotta, Reuters, 12/2/20

[5]The American Crisis, by Thomas Paine, December 1776

[6]Pfizer says COVID-19 vaccine is looking 90% effective, by Lauran Nergaard and Linda A. Johnson, Associated Press, 11/10/20

[7]Moderna's COVID-19 Vaccine Shines In Clinical Trial, by Joe Palca, NPR, 11/16/20

[8]Politics, Science and the Remarkable Race for a Coronavirus Vaccine, New York Times, by Sharon LaFraniere, Katie Thomas, Noah Welland, David Gelles, Sheryl Gay Stolberg and Denise Grady, 11/21/20

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

[10]Oxford AstraZeneca Covid vaccine has up to 90% efficacy, data reveals, by Sarah Bosely and Ian Sample, The Guardian, 1/23/20

[11]COVID-19 Vaccine Tracker, posted by Jeff Craven, Regulatory Affairs Professional Society, 12/3/20

[12]Long-Term-Care Residents and Health Workers Should Get Vaccine First, C.D.C. Panel Says, by Amy Goodnough, New York Times, 12/1/20

[13]Operation Warp Speed's top scientist predicts more than 100 million Americans could be immunized with coronavirus vaccines within the next 100 days, by Andrew Dunn, Business Insider, 12/2/20

[14]Clinical Outcomes of a COVID-19 Vaccine: Implementation over Efficacy, by A. David Paltiel, Jason L. Schwartz, Amy Zheng and Rochelle P. Walensky, Health Affairs 11/19/20

[15]2 Companies Say Their Vaccines Are 95% Effective. What Does That Mean?, by Carl Zimmer, New York Times, 11/20/20

About the Author

John J. Dalton, FHFMA, Senior Advisor Emeritus at BESLER and Executive Director of the Healing American Healthcare Coalition, is a former Chapter President, National Board member, and HFMA's 2001 Morgan Award winner for lifetime achievement in healthcare financial management, the only New Jersey Chapter leader to receive that honor. He serves on the Finance Committee at Children's Specialized Hospital 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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The Codification of Medicare Bad Debt

by Amy Duncan

When CMS modifies Medicare Bad Debt (MBD) reimbursement guidelines, it gets attention. Mainly because the MBD Program stood on four vague pillars from the Provider Reimbursement Manual ("PRM") for more than 20 years. Regional MAC office audits and court decisions had further refined those guidelines over the years.

In 2008, the Joint Signature Memo required accounts be returned from final collection agency prior to MBD qualification. Now almost all Providers across the country have implemented some sort of close and return process to preserve their self pay Medicare Bad Debt reimbursement (if your System hasn't, let's talk!).

Then in April 2019, an MLN Connects confirmed then-recent Palmetto and Novitas audit adjustments; Medicare/Medicaid ("Crossover") accounts needed to be written down to a bad debt expense transaction code, rather than a contractual allowance (cost reports beginning October 1, 2019). The FY2021 IPPS Final Rule attempts to clarify this memo:

- Before October 1, 2020: Bad Debt must be written down to a bad debt expense code
- After October 1, 2020: Bad Debt is an implicit price concession and must be written down to a revenue account.

The above could be interpreted as Medicare retroactively disqualifying all Medicaid contractual allowances from MBD reimbursement, as well as charity, deceased and bankrupt write-offs, for all prior, open cost reports. Recent discussions with various MACs indicate this rule will be enforced on cost reports October 1, 2019 and later, per the April 2019 MLN. We will advise our mailing list should any audit prior to October 1, 2019 receive adjustments for Medicaid contractual allowances.

In addition to the IPPS Final Rule, CMS published a notice in the Federal Register dated November 10, 2020, in accordance with the Paperwork Reduction Act (PRA) of 1995. This notice proposes a revised Medicare Bad Debt template (referred to as Exhibit 2A) and includes 25 columns. This will be for cost reports with fiscal year beginning on or after 10/1/2020. The additional columns indicate that the MAC will be examining the listings more closely before a sample is chosen.

We know you're thinking, "Other than that, Mrs. Lincoln…". Yes, yes, there's more to the FY2021 IPPS Final Rule, and it's not doom and gloom. The remaining regulations refine "Reasonable Collection Efforts" to codify long-standing MAC audit requirements which have been inconsistently applied across the country.

Specifically, for each category of MBD, Reasonable Collection Efforts are now defined as the following:

Non-Indigent (Also referred to as "Self Pay" or "Traditional")

- **Timely Patient Billing:** Patient must be billed within 120 days of (1) the date of the Medicare remittance advice; or (2) the date of the remittance advice from the beneficiary's secondary payer, if any; whichever is latest. Most MACs have historically required a statement sent within 75 or 90 days, so 120 days to produce a patient statement seems equitable. The additional Exhibit 2A fields for Medicaid and secondary commercial remittance dates will most likely assist auditors in calculating compliance
- **120 Days**: The widely accepted "3 statements/120 days" guidance was further clarified by requiring a restart of the 120-day collection timeframe anytime a partial payment (of any amount) is received. The 120 days can include collection agency activity, so policies with outside collection agencies need to include criteria of no payment within 120 days before returning account to Provider. Exhibit 2A does not include a column for "date of last patient payment" so this cannot be validated by the auditor using only the worksheet, therefore, additional Provider and agency documentation will be necessary at the time of the audit.
- **Similar Collection Effort**: The Provider as well as any agencies (including early out) must use similar practices for comparable amounts on Medicare and non-Medicare accounts. Fee charged by agencies is not considered reimbursable MBD. Many audits are now requesting patient account and agency history on non-Medicare accounts to compare effort, so it's very impor-

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tant to confirm Medicare accounts are treated with the same rigor as non-Medicare prior to MBD list submission.

- **Documentation Retention**: Providers must retain the relevant bad debt policy, account history (showing payments, statements sent, etc) and copies of beneficiary statements. Most Providers do not retain actual print-image patient statements, but we're optimistic a "template" statement will suffice, as it has in recent audits, particularly given the increased popularity of bill payment applications.

Non-Dual Eligible Indigent (also referred to as "Charity", "Deceased" or "Bankrupt")

- **Determination:** The PRM required analysis of income, assets, liabilities and expenses. The latter two were rarely examined during past MBD audits and have been eliminated from these new requirements. The Final Rule also states Providers cannot use patient declaration as the sole proof of indigence and must consider income and assets (convertible to cash and unnecessary for daily living). We understand this to mean the Provider needs to require documentation to support the patient-signed application. Proof of income, tax returns, bank statements, social security statements (anything required in the provider's policy) needs to have the corresponding patient detail. CMS also went out of its way to underscore the asset test's importance by saying it's aware of other State indigent programs restriction on asset checks and that if MBD reimbursement is desired, the asset check will be still required.
- **Presumptive Eligibility**: Codifying presumptive scoring's non-compliance is expected, these are just not eligible for Medicare reimbursement. Presumptive accounts are not accepted at audit as the patient has never attested to the financial information (no signed application nor supporting documentation collected).
- **Documentation Retention**: Provider must retain policy, applications and supporting documentation. Most Providers scan these policies for easy retrieval at a future date.

Dual Eligible Indigent (Also referred to as "Crossover")

- **Remittance Advice:** If the State Medicaid remittance is not available (which is considered the most solid support), other substitutes will be considered. This is widely used for certain community mental health payers or other non-835 remitting payers.

The detailed explanations for "Reasonable Collection Effort" outlined above reflect the depth and granularity of recent MBD audits. Providers spend hundreds of hours compiling MBD listings, and an increasing number of hours are now spent defending those MBD listings during MAC audit. Three additional audit checks not included in the final regulations have been on many MAC checklists and we believe would assist in "future-proofing" Provider MBD listings, as much as possible:

1. **Return Transaction:** Recent audits have required a financial transaction to zero out the bad debt receivable balance upon self pay account return from final collection agency. This was not addressed in the Final Rule but appears to be a new column on Exhibit 2A ("Medicare Write Off Date" v the agency close date of "Collection Effort Cease Date"). Because of this added column and recent MAC audit check, we recommend posting a return transaction when accounts are closed at final agency. This transaction needs to be posted very close to the agency close date to avoid what auditors refer to as a "lag in collection efforts".
2. **Consistent Collection Effort**: Recent audits have required a patient statement to be sent every 30 days after the 1st billing statement. If there is a lag in the collection effort, it has been disallowed and considered inconsistent collection effort. The Final Rule did not clarify "consistent collection effort" but we recommend reviewing Medicare and non-Medicare collection efforts across the collection life cycle.
3. **Charity Calculator or Checklist**: Very recent audits have required the checklist used by the financial counselor to determine the level of financial assistance granted. This requirement had seemed unnecessary when only income was used to qualify accounts. With the codification of the asset test requirement, we recommend retaining scanned documentation of how the financial assistance percentage was determined.

There is so much more to Medicare Bad Debt than relying on canned system extracts or single source reporting for hospital listings. At the very least, Providers should review their internal edits to comply with the above requirements. In addition, Providers should also review the revised Exhibit 2A and deliver any comments to CMS by the January 11, 2021 deadline.

About the Author

Amy Duncan is the Founder and President of Collaborative Data, Inc. For over 11 years, CDI has offered concierge-style Medicare Bad Debt and S-10 services, providing comprehensive, fully-tested listings and audit support for both current year and retrospective reviews. Prior to CDI, Amy was a National Lead of the EY Medicare Bad Debt product line. Amy can be reached at Amy.Duncan@collaborativedatainc.com.

Provider Relief Funds: Summary and What's Next

Domenic Segalla

by Domenic Segalla

The Coronavirus Aid, Relief, and Economic Security (CARES) Act (P.L. 116-136) and the Paycheck Protection Program and Health Care Enhancement Act (P.L. 116-139), appropriated funds to reimburse eligible healthcare providers for healthcare related expenses or lost revenues attributable to the coronavirus. These funds were distributed by Health Resources & Services Administration (HRSA) through the $175 billion CARES Act Provider Relief Fund (PRF) program. Recipients of these funds agreed to Terms & Conditions, which require compliance with reporting requirements as specified by the Secretary of Health and Human Services in program instructions. The PRF's were distributed to providers via two rounds of general allocation funding and several targeted allocations. Each allocation has a set of terms and conditions that providers must agree to when attesting to receipt of the funds.

General Allocation Funding: HHS allocated $50 billion in general funding proportional to providers' share of 2018 net patient revenue. HHS designed its allocation methodology to provide payments to Medicare fee-for-service providers based on the lesser of 2% of a provider's 2018 (or most recent complete tax year) net patient revenue or the sum of incurred losses for March and April. On April 10, CMS distributed the first round of general allocation funding — $30 billion — to hospitals via direct grants based on the proportion of Medicare fee-for-service revenue received by the hospital in 2019. Automatic payments were distributed to providers via Optum Bank with "HHSPAYMENT" as the payment description or via paper checks. A second round of $20 billion in general allocation funding was announced on April 22. HHS distributed the additional $20 billion automatically — based on a provider's share of 2018 net patient revenue — as part of its $50 billion overall general allocation.

Targeted Allocations: HHS also disbursed the following approximate "targeted" allocations:

- $22 billion for hospitals in COVID-19 high-impact areas
- $10 billion for rural hospitals and rural health clinics (RHCs), as well as $1 billion to specialty rural hospitals, urban hospitals with certain rural Medicare designations, and hospitals in small metropolitan areas
- $13 billion for safety net providers
- $4.9 billion for skilled-nursing facilities
- $400 million for the Indian Health Service

Allocation for treatment of the uninsured: HHS distributed approximately $15 billion to eligible providers that participate in state Medicaid/Children's Health Insurance Program (CHIP) or Medicaid managed care plans and have not yet received a payment from the PRF general distribution allocation. Additional information on each targeted allocation is provided below:

• **COVID-19 High-Impact Areas**: On May 1, HHS announced an initial allocation of $12 billion to 395 hospitals that provided inpatient care for 100 or more COVID-19 patients through April 10. $2 billion of this amount was distributed to these hospitals based on their Medicare and Medicaid disproportionate share and uncompensated care payments. Hospitals are paid a fixed amount per COVID-19 inpatient admission, with an additional amount taking into account their Medicare and Medicaid disproportionate share and uncompensated care payments.

On July 17, HHS announced an additional $10 billion distribution to hospitals in high-impact COVID-19 areas based on a formula for hospitals with over 161 COVID-19 admissions between Jan. 1 and June 10, or one admission per day, or that experienced a disproportionate intensity of COVID-19 admissions (exceeding the average ratio of COVID-19 admissions/beds). Eligible hospitals were paid $50,000 per eligible admission. The first round of funding was based on a formula that distributed funds to hospitals with 100 or more COVID-19 admissions between Jan. 1 and April 10 and paid $76,975 per eligible admission. These previous high-impact payments were also taken into account when determining each hospital's payment from the second-round distribution.

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• **Rural Allocations**: HHS distributed $10 billion in allocation to rural hospitals, critical access hospitals (CAHs), community health centers (CHCs) located in rural areas. Al locations were a minimum of $1 million to each hospital and $100,000 to each clinic. These providers were able to qualify for additional funds based on the relative proportion of operating expenses they represent across the entirety of rural healthcare. The minimum base payment was meant to ensure that providers without Medicare claims, such as pediatric clinics, still receive adequate support. HHS also disbursed an additional allocation of $1 billion to urban hospitals with certain rural Medicare designation, as well as others that provide care in smaller non-rural communities. These includes some suburban hospitals that are not considered rural but serve rural populations and operate with smaller profit margins and limited resources than larger hospitals.

• **Safety Net Allocations**: A total of $13 billion has been distributed in the HHS safety net allocation. The first $10 billion was announced on June 9, and eligible hospitals received between the minimum distribution of $5 million and a maximum distribution of $50 million. HHS defined eligible safety-net hospitals as those with a Medicare disproportionate payment percentage of 20.2% or greater and average uncompensated care per bed of $25,000 or more. Profitability of 3% or less, as reported to the Centers for Medicare & Medicaid Services (CMS) in the most recently filed cost report. On July 10, HHS announced $3 billion in additional safety-net hospital funding and expanded the criteria for qualification to include certain acute care hospitals that meet a revised profitability threshold of less than 3% averaged consecutively over two or more of the last five cost reporting periods, as reported on the Medicare cost report.

• **Children's Hospital Allocation**: $1.4 billion was distributed to approximately 80 freestanding children's hospitals. To qualify, the hospital was either an exempt hospital from the Medicare inpatient prospective payment system or be a HRSA-defined Children's Hospital Graduate Medical Education facility. Eligible hospitals received 2.5% of their net revenue from patient care.

• **Skilled-Nursing Facility Allocation**: $4.9 billion was distributed to skilled-nursing facilities (SNFs), including distinct part nursing facilities. The funding is intended to help nursing homes address critical needs

such as labor, scaling up their testing capacity, acquiring personal protective equipment, and a range of other expenses directly linked to this pandemic. HHS distributed funding to all certified SNFs with six or more certified beds on both a fixed basis and variable basis. Each SNF received a fixed distribution of $50,000, plus a distribution of $2,500 per bed. Providers must attest to the terms and conditions for this allocation. On August 27, HHS announced an additional distribution of $2.5 billion to nursing homes and skilled-nursing facilities, based on a per-facility payment of $10,000 plus a per-bed payment of $1,450. To be eligible, a facility was required to have at least six certified beds. As of this writing, HHS allocated an additional $2 billion to nursing homes and skilled-nursing facilities based on certain performance measures.

• **Treatment for the Uninsured**: Every healthcare provider who has provided treatment for uninsured COVID-19 patients on or after February 4, 2020, can request claims reimbursement through the program and will be reimbursed at Medicare rates, subject to available funding. Providers must enroll in the COVID-19 Uninsured Program, which will be overseen by the Health Resources & Services Administration (HRSA). Further information, including frequently asked questions and a COVID-19 Uninsured Program portal user guide, can be found on the HRSA website.

• **Indian Health Services**: $400 million was distributed for Indian Health Service facilities, distributed on the basis of operating expenses.

• **Medicaid and CHIP Allocation**: HHS distributed approximately $15 billion to eligible providers that participate in state Medicaid and CHIP and had not received a payment from the PRF general allocation. The payment to each provider approximated 2% of reported gross revenue from patient care; the final amount each provider received was determined after the data was submitted. Applications were due to HHS by September 13, 2020. Additional information is available in a Medicaid and CHIP allocation fact sheet.

On Oct. 1, 2020, the U.S. Department of Health and Human Services, through the Health Resources and Services Administrative (HRSA), announced $20B in new Phase 3 General Distribution Funding for providers from the Public Health and Social Services Emergency Fund (Provider Relief Fund). Providers that previously received funding, previously ineligible providers that began practicing in 2020, and an expanded group of behavioral health providers were eligible to apply for additional relief funding. Providers had until Nov. 6, 2020, to apply for Phase 3 Funding. The intent of Phase 3 funding is to assure all eligible providers receive at least 2% of their 2019 Net Patient Service Revenue from all PRF distributions including Phase 3. Any dollars remaining of the $20B will then be reallocated to all eligible providers under a methodology not yet revealed. Funding is anticipated to occur prior to 12/31/20.

Current Stimulus Proposal: The White House recently offered a $916 billion pandemic stimulus proposal that would meet demands to provide some relief to state and local governments and include liability protections for businesses and healthcare providers alike.

Included in the proposal for healthcare, is approximately $100 billion broken into three components:

- $30 billion for healthcare testing and contact tracing of COVID 19
- $30 billion of "relief funds and virtual care expansion"
- $40 billion in forgiveness (conversion to grants) of approximately 40% of the outstanding Accelerated Advance Medicare Loan payments. This would eliminate 40% of amounts coming due over the next approximate eighteen months for those who received the loans.

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•Focus on Finance•

Employment Tax Reporting and Here Comes 2020 Form 1099 Changes!

Scott Mariani

By Scott Mariani

Employment tax is always an area of scrutiny by the IRS and state taxing authorities; particularly in the healthcare industry. Audit issues include reclassification of workers from independent contractor to employee; an individual receiving both a Form W-2 and Form 1099 in the same calendar year; incorrect employment tax forms preparation, the failure to issue Forms 1099 and general non-compliance with Form W-9 record keeping. Form 1099 non-compliance penalties for failure to file and failure to furnish can be substantial as well as the imposition of backup withholding, which is currently 24% for tax years through 2025 for non-maintaining certain vendor completed Forms W-9.

For calendar year 2020 employment tax reporting, the IRS has created more complexity with the creation of Form 1099-NEC; nonemployee compensation ("NEC") and revising Form 1099-MISC miscellaneous income.

Q. What are the significant changes to employment tax reporting?

A.

- The Form 1099-NEC generally replaces Form 1099-MISC, Box 7 nonemployee compensation and these payments should now be reported in Box 1 of Form 1099-NEC. However, please note that there may be an opportunity to report certain of these payments on Form 1099-MISC Box 6 as medical health care payments in lieu of Form 1099-NEC.
- Different due dates with respect to Forms 1099-NEC and Forms 1099-MISC. The 2020 Form 1099-NEC is due to both recipients and the IRS by February 1, 2021, regardless of whether filing electronically or by paper. The 2020 Form 1099-MISC is also due to recipients by February 1, 2021; however, Forms1099-MISC are due to the IRS by March 1, 2021 for paper filing or by March 31, 2021 for electronic filing.
- Modifications to electronic filing requirements with respect to Forms W-2 and Forms 1099. The electronic filing threshold remains at 250 or more forms filed for tax year 2020 but drops to 100 forms and 10 forms; respectively, for calendar years 2021 and 2022. Please note however that the reduced thresholds outlined herein are pending issuance of the Regulations at a future date.
- Individual state filing requirements are not yet known as the IRS has not communicated whether the Form 1099-NEC will be included in the combined federal/state filing program. Publication 1220 was revised in September 2020 and the Form 1099-NEC was still not listed as being included in this program. Taxpayers should continue to monitor for any IRS updates as well as individual updates from their specific states.

Q. What are some employment tax recommendations?

A. The IRS and state taxing authorities consistently review employment taxes for non-compliance. As a result, and given the year 2020 changes relating to the Forms 1099-NEC and 1099-MISC we recommend a comprehensive review of your employment tax reporting function including:

- Payroll and accounts payable personnel should identify and review any workers who may be receiving both a Form W-2 and Form 1099.
- Your written worker classification policy should be reviewed and potentially revised.
- Your accounts payable files should include a fully completed Form W-9 for all vendors.
- A review of all your current "non-1099 required" vendors should be completed for purposes of whether a Form 1099-NEC or MISC should be issued given the changes and new reporting requirements.

- A determination should be made as to whether each of your "Form 1099 required" vendors should be issued a Form 1099-NEC or Form 1099-MISC given the changes and new reporting requirements.
- Certain previously issued Form 1099-MISC Box 7 non-employee compensation reporting should be reviewed to determine whether to report certain vendors and payments on either Form 1099-NEC or Form 1099-MISC Box 6, medical health care payments.
- Your written accounts payable policy should be revised and updated for the Form 1099-NEC.
- Your new vendor policy should be revised and updated for the Form 1099-NEC.

We recommend that an organization forms an internal working group to accomplish the above tasks which includes representatives from finance, IT, legal and internal audit. Moreover, documentation of the process undertaken with respect to the above review should also be maintained particularly in the event of an IRS or state employment tax audit examination. Please contact a member of Withum's Healthcare Services Group with any questions.

About the author

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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

Healthcare Financial Analyst
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CentraState Healthcare System

Accountant
Project Hope Inc.

Decision Support Analyst - Lawrenceville, Nj
Capital Health

Senior Manager Of Provider Reimbursement
O'Conco Healthcare

Chief Financial Officer
New Jersey Hospital Association

New Jersey Board of Public Utilities Announces Opening of Year 2 of the Community Solar Program

Barbara J. Koonz

by Barbara J. Koonz

On October 2, 2020, the New Jersey Board of Public Utilities (Board) announced the opening of the second year of the Community Solar Program (PY2) as well as various changes from Program Year 1 (PY1) of the program. The Board stated that during PY2 it will expand the program capacity from 75MWs to 150MWs – 60MWs of which will be set aside for low and moderate income (LMI) subscribers. The deadline for the submission of applications for PY2 is February 5, 2021, however projects that cannot meet that application deadline can instead apply during PY3.

The Community Solar Program is mandated by the Clean Energy Act of 2018 and is intended to make renewable energy accessible and affordable to LMI customers and to Environmental Justice Communities. In 2019, the Board commenced the Community Solar Program by establishing a three year "pilot program" to develop community solar projects of at least 75MWs per year. Under the Community Solar Program, residential and commercial customers that lack sufficient space for the installation of solar photovoltaic equipment to generate electricity for their own consumption can enter into a subscriber agreement that enables them to purchase electricity generated by solar facilities located on other properties.

The Community Solar Program is mandated by the Clean Energy Act of 2018 and is intended to make renewable energy accessible and affordable to LMI customers and to Environmental Justice Communities.

Solar developers throughout New Jersey have shown widespread interest in the program. During PY1, 252 applications were submitted to the Board. In December 2019, the Board approved 45 applications consisting of 78MWs – all of which will serve a subscriber base where more than 51% of the subscribers are LMI customers.

After conducting stakeholder "lessons learned" sessions regarding PY1, the Board determined to make various modifications for PY2, including the following:

- The six-month deadline for beginning construction will be eliminated and replaced with a quarterly status reporting obligation
- The construction completion requirement shall be extended from 12 months to 18 months and extensions will be limited to one, 6-month extension;
- Expansion of criteria that developers may use to confirm LMI qualification of subscribers;
- Permitting the annual program capacity limit for PY2 and PY3 to be determined during the program year rather than in advance as required by the current program regulations;
- Establishment of financial penalties if a project fails to satisfy its financial commitments made in its program application, particularly regarding LMI customers;
- Approval of automatic enrollment of subscribers ("opt-out") for municipally owned and operated projects that guarantee customer savings and provide appropriate consumer privacy protections;

- The capacity for PY2 expanded to 150MWs – with 60MWs set aside for LMI projects;
- PY2 projects will be eligible for Transition Renewable Energy Certificates (TRECs) even though the TREC program will likely expire sometime in 2021;
- Applications will be required to be filed no later than February 5, 2021 through an online portal; and
- The local electric utilities are required to submit a report to the Board no later than February 26, 2021 setting forth a proposal for consolidated billing.

The PY2 criteria for evaluating applications and awarding project approvals will generally track that used in PY1. Applications will be reviewed and scored based on evaluation criteria that includes:

- LMI and environmental justice inclusion (25 points max.);
- Siting – with priority given to landfills, brownfields, and parking lots among others, and bonus points for site enhancements, or locating in a redevelopment or opportunity zone (20 points max. plus bonus points);
- Community and environmental justice engagement (15 points max.);
- Product offering, with a preference for guaranteed customer savings of greater than 20 percent and flexible terms (15 points max.);
- Other benefits such as job training and co-benefits such as energy storage, EV charging, or energy efficiency (10 points max.); and
- Geographic location within utility service territory and project maturity (each 5 points max.).

Project applications must receive a minimum of 50 points to be considered, and will be awarded capacity in descending order beginning with the highest-scoring project in each electric utility's territory. The **application form for PY2** is available on the BPU Office of Clean Energy website. Projects that cannot meet the PY2 application deadline can apply during program year 3.

While Community Solar projects are attractive to project developers and customers without adequate space to install their own solar generation facilities, because of the availability of Transition Renewable Energy Certificates (TRECs) there remain strong economic incentives for the development of on-site solar facilities for energy users that have sufficient space to install solar facilities on rooftops, parking lots or open space. The TREC program may close as soon as the second quarter of 2021. Hospitals or medical facilities that would benefit from solar generation should evaluate solar options as soon as possible to ensure that their potential projects can qualify for valuable TREC subsidies.

Under the Community Solar Program, residential and commercial customers that lack sufficient space for the installation of solar photovoltaic equipment to generate electricity for their own consumption can enter into a subscriber agreement that enables them to purchase electricity generated by solar facilities located on other properties.

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Barbara J. Koonz is a partner in the Environmental Department at Greenbaum, Rowe, Smith & Davis LLP, where she chairs the Energy, Renewable Resources & Sustainable Development Practice Group. She focuses her practice in the areas of environmental and energy law, with an emphasis on environmental permitting for redevelopment, environmental compliance and renewable energy projects. She can be reached at 973.577.1894 or by email at bkoonz@greenbaumlaw.com.

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Proposed Changes to the Medicare Cost Report and Instructions

Michael Newell

by Michael Newell

On Tuesday, November 10, 2020, The Centers for Medicare & Medicaid (CMS) issued a Federal Register notice required under the Paperwork Reduction Act (PRA) of 1995 announcing an opportunity for the public comment to CMS's "intention to collect information from the public."

The information to be collected from this particular notice is associated with the CMS-2552-10 Hospital and Health Care Complex Cost Report and covers a wide range of Medicare cost report topics.

On the CMS website, there's a link for a zip file with proposed supporting documents. Once you click on that, you'll find the following:

1. Supporting Statement for Form CMS-2552-10
2. Chapter 40 Hospital and Hospital Health Care Complex Cost Report Form CMS-2552-10 in the Medicare Provider Reimbursement Manual (PRM)
3. Draft of Form CMS-2552-10
4. Crosswalk detailing the updates and information to be collected

This alert will briefly touch on several of the changes, but not all. Please refer to the CMS website to see all PRM changes covered by this action.

Proposed Changes to Medicare Cost Report

The proposed revisions and additions include changes to the PRM cost reporting instructions and changes to the cost reporting form, including new worksheets and supporting data templates. Changes touch the following cost report worksheets:

- Worksheet S-2, Part I
- Worksheet S-2, Part II
- Worksheet S-3, Part I
- Worksheet S-10
- Worksheet S-12 (New worksheet)
- Worksheets A, B (Parts I and II), B-1 and C (Parts I and II)
- Worksheet D, Parts II, IV, V
- Worksheet D-1
- Worksheet D-4
- Worksheet D-6 (New worksheet)
- Worksheet E, Part A
- Worksheet E-5
- Worksheet G-3
- Worksheet L-1, Part I

Worksheet S-2, Part I: New Exhibit 3A—Listing of Medicaid Eligible Days for DSH Eligible Hospital

Effective with cost reporting periods beginning on or after October 1, 2018, hospitals were required to submit a listing supporting Medicare Disproportionate Share Hospital (DSH) eligible days claimed in the cost report at the time of submission. Failure to do so would result in the rejection of the cost report. However, CMS offered no standardized format for submitting the required data. That is being changed here.

In addition to revisions in reporting Medicare DSH eligible days data on Worksheet S-2, Part I lines 24 and 25, columns 1-6, CMS has now presented a standardized format to submit the patient level detailed information. This can be found in the new Exhibit 3A and is required for cost reporting periods beginning on or after October 1, 2020. Note, patient-level detail is required for each category of days reported on lines 24 and 25, columns 1 through 6.

The new exhibit, which is found on page 54 of the CMS PRM Chapter 40, has 18 columns and includes the following data points:

- Patient name, last and first
- Date of birth
- Gender
- Medicaid ID number (particularly for paid claims)
- Dates of service, admit and discharge
- Medical record number
- Account number
- State eligibility code

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- Medicaid days, eligible days and labor and delivery room days
- Insurance or other payer, primary and secondary
- Medicare eligibility, type, start and end dates
- Comments

Worksheet S-2, Part II: Exhibit 2A—Listing of Medicare Bad Debts

A listing for Medicare bad debts has been required for years and for cost reporting periods beginning on or after October 1, 2018, providers were to use Exhibit 2. Failure to do so would result in the rejection of the cost report.

For cost reporting periods beginning on or after October 1, 2020, hospitals are now expected to submit Exhibit 2A. If applicable, a separate Exhibit 2A should be submitted for each provider number in the health care complex and separated by inpatient and outpatient as well. Also, the exhibits should distinguish between dually eligible crossover accounts and non-dually eligible accounts.

The new exhibit, which is found on page 67 of the CMS PRM Chapter 40, has 25 columns and includes the following data points:

- Patient name, last and first
- Medicare beneficiary identifier (MBI) or HICN
- Patient account number
- Dates of service, from and to
- Medicaid number
- Deemed indigent indicator
- Remittance advice date, Medicare and Medicaid
- Secondary payer remittance advice date
- Beneficiary responsibility amount
- Date first bill sent to beneficiary
- A/R write-off date
- Collection agency information, sent and returned dates
- Collection effort cease date
- Medicare write-off date
- Recoveries, amount and Medicare FYE date
- Medicare deductible and coinsurance amounts (expectation of payment criteria required)
- Current year payments received, amount and source
- Allowed bad debts
- Comments

Worksheet S-10: New Proposed Instructions

CMS has revised the Worksheet S-10 instructions and some of the proposed changes include:

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

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

Worksheet S-10: New Exhibit 3B—Charity Care Listing

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

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

- Patient name, last and first
- Dates of service, admit and discharge
- Patient account number
- Uninsured (UI) or insured (INC) but any of the following are true:
    - There's no contractual relationship with the hospital
    - Medically necessary, non-covered services were pro vided
    - The patient had exhausted benefits
- Name of Insurer
- MBI
- Medicaid number
- Charity care determination, approved and policy under which approved
- Gross charges
- Deductible, coinsurance, and co-payment
- Non-covered charges by Medicaid
- Minus reductions for the following:
    - Physician professional charges
    - Non-covered charges

  - Uninsured discount
  - Contractual allowance
  - Courtesy discount
- Gross charges net of reductions
- Allowable charity charges
- Charity care approved ratio
- Uninsured discount
- Total allowable charity care amount
- Write-off date
- Patient responsibility charges
- Payments received

Worksheet S-10: New Exhibit 3C—Listing of Total Bad Debts

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

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

- Insurance status
- Patient name, last and first
- Patient ID number
- Dates of service, from and to
- Primary payor
- Secondary payor
- Service indicator, inpatient (IP) or outpatient (OP)
- Total hospital charges, hospital CMS certification number (CCN) only
- Total physician or professional charges
- Total patient payments
- Total third-party payments
- Patient charity care amount
- Contractual allowance or other amount
- A/R write-off date
- Patient bad debt write-off amount

Worksheet S-12: Median Payer Specific Negotiated Charge Data

In accordance with the FY 2021 Inpatient Prospective Payment System (IPPS) final rule, CMS is adding a new worksheet to the cost report to collect data associated with payer specific negotiated charge information. This information must be reported for cost reporting periods ending on or after January 1, 2021. All Medicare Advantage Organizations (MAOs) must report the median payor specific negotiated charge in the cost report for each MS-DRG. See the FY 2021 IPPS final rule, published on September 18, 2020, for more information.

Worksheet A; B Parts I and II; B-1; C Parts I and II; D Parts II, IV and V; D-6; L-1 Part I

Instructions were updated to clarify reporting for:

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

Worksheet D-1—Computation of Inpatient Operating Costs

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

Worksheet D-4—Computation of Organ Acquisition Costs

Instructions have been revised to regarding the counting of organs including total usable organs, Medicare usable organs, organs for Medicare Advantage patients, and organs where there is a primary and secondary payer.

Worksheet E Part A—Calculation of Reimbursement Settlement

Instructions have been added for excluded MS-DRG's effective for cost reporting periods beginning on or after October 1, 2020. For further information, see page 58,844 of the FY 2021 final IPPS rule issued September 18, 2020.

Worksheet G-3–Statement of Revenue and Expenses

Instructions added regarding the reporting of revenue received for COVID-19 PHE funding.

Public Comments

There are significant additional reporting requirements for this proposal and providers were encouraged to review all supporting documents carefully and if appropriate make comments.

Comments regarding these proposed changes and collection activities, including the effort needed to comply, were to be submitted no later than January 11, 2021.

About the author

Michael Newell is a partner at Moss Adams and has worked in health care financial management since 1982. He's worked with hundreds of hospitals for thousands of fiscal years to prepare and review Medicare DSH and Worksheet S-10 for cost report filings. Moss Adams prepares over 550 Medicare DSH reports for hospital clients annually and prepares over 200 Uncompensated Care S-10 reports annually. For more information on these proposed requirements and how they will affect your organization, compiling the required data, or for help with your organization's compliance or Medicare cost reporting efforts, Michael can be reached at michael.newell@mossadams.com.

Healthcare Reimbursement?

by John Manzi and Mike Sabo

John Manzi

Mike Sabo

As the careers of Mike Sabo and John Manzi continue to expand, many of their colleagues have asked: What led you to choose to be healthcare reimbursement professionals and does reimbursement still retain its importance in today's everchanging healthcare field?

Mike & John's careers took totally different paths in choosing reimbursement. As their career workplan developed, they soon discovered many connections, which continue today.

Before Mike began his career, he attended and graduated from Farleigh Dickerson University in North Jersey. He graduated with a degree in Accounting. While first interviewing during the last semester in college, Mike quickly found out that the "Big 8" (now the "Big 4") accounting firms were not for him. During an interview, he said to himself what the hell am I doing here, I hate this "crap". After talking to his accounting professor, he got Mike an interview with another former student who thought the same as Mike 5 years earlier. During the interview Mike thought this is a better more challenging path – Medicare and Medicaid reimbursement.

So, Mike's first job was with New Jersey Blue Cross and Blue Shield which was then the prominent Medicare and Medicaid reimbursement "Fiscal Intermediary" (now known as a MAC) in the state. His career brought him to work at archrivals Jersey Shore Medical Center and Monmouth Medical Center. When the Barnabas Health System acquired Monmouth, Mike moved into a general finance position for their System Corporate Finance reporting monthly financial data, located in Toms Rover. He then went back to his reimbursement roots by moving to the competitive consulting side of the business working for KA Consulting (CBIZ), where he rejoined working with his buddy John. Five years later he moved to their rival Besler Consulting. After adopting two children, Mike went back to the hospital side at Meridian Health, in which Jersey Shore Medical Center was their flagship. As the children grew, Mike missed working with clients, engaging with clients, so in 2010 he moved back to consulting.

His current stop is with REVINT, which just recently rebranded to Cloudmed. He is involved with major regulatory and reimbursement issues including SSI, Charity Care, S-10 and many hospital reimbursement cost report issues, reopenings and appeals.

John's career path was so different than Mike's. He graduated from Trenton State with a degree in Accounting and found his first job working at Cooper Medical Center in Camden. To enhance his job skills, John assisted in performing assigned accounting functions including closing the monthly General Ledger by hand. Yes, each departmental expense was handwritten on ledger paper and accumulated in a huge binder! He moved on to plant ledger accounting and one day was asked to try a new adventure, the completion of the Medicare Cost Report (MCR).

The Medicare Cost Report was a totally different reporting format. It continued to be a manual process but there were payments, costing, statistics, and a new buzz word: the stepdown. The stepdown is like someone sliding down a ladder. You accumulate all you overhead costs like A&G and step them down, one at a time into the room & board and ancillary revenue centers. This ensures you accumulate full cost to match against all the charges generated in each revenue cost center. This product is commonly known as a RCC or ratio of cost to charge. The time to complete a manual step down was days and the ability to utilize a calculator with one hand was a true benefit. The word "plug" was emphasized as sometimes it was necessary to make the stepdown tie. Once completed, the next function was to complete the hospital's gross revenue and Medicare payments. John soon discovered if you changed a cost, a statistic or departmental revenue, the hospital could receive more reimbursement from Medicare and Medicaid. Reimbursement became a total transformation from accounting, allowing him to begin "thinking outside the box".

As a reimbursement professional, John interacted with Billing, Medical Records, Accounts Payable, Physicians and Administration. He oversaw all the Medicare Intermediary Audits. They would stop by each year and audit the records utilized to complete

the MCR. John's goal was to provide the best support and preserve the paid Medicare reimbursement from the previous year. He once had the Medicare auditors ask if they could verify the square footage of one of their clinics. John asked a new employee, Don, to show the auditors the clinic building, which was across the street. Don came back in an hour and John asked how it went? Don said "Great! The auditors agreed with the square footage of the building." John, wondering why the visit took so long, asked Don what building he showed the auditors? Don pointed to the building down the street. John started laughing and told Don, "Cooper Medical Center does not own that building!!!"

One of those auditors who visited John to review the Medicare Cost Report at Cooper Medical Center was Mike Sabo. The two immediately formed a friendship that is still close today, even though Mike grew up in Central Jersey and John in South Jersey. Mike was a Mets and Jets fan, while John cheered for the Phillies and Eagles. The two even ended up not only living in the same town, but also working together at Monmouth Medical Center and CBIZ. They still talk every week and bounce reimbursement questions off each other.

John ended up spending three years at Cooper Medical Center and then took a new job at Monmouth Medical Center in Long Branch. During his job search, John turned down a job to work for Gene Arnone in Atlantic City. Gene and Ray Kaden soon started the iconic reimbursement firm of Kaden & Arnone, in time becoming CBIZ KA. John eventually joined the firm, but many years later.

John also holds the distinction of being the first to utilize a computer program to prepare a Medicare Cost Report in the state of New Jersey while at Cooper. And, when John moved on to Monmouth Medical Center three years later where they were still working manually, ironically, he was also the last in New Jersey to complete a manual report before Monmouth transitioned to the new technology.

Both Mike and John chose Reimbursement as a profession. They loved the challenge of figuring out new CMS regulations, reviewing MCR, completing feasibility studies, creating reimbursement worksheets and products to enhance the receipt of federal funds to hospitals and other healthcare facilities. Reviewing a Medicare Cost Report in a day can be considered one of the hardest work requests in the healthcare financial workplace. The reviewer needs to check for accuracy, compliance, and enhanced reimbursement, all the while reviewing very technical and extensive workpapers. John once was asked to prepare a Medicare Cost Report for a North Jersey Hospital. He asked for their last year's workpapers to follow and was given a large brown bag full of papers. As a consultant, all John could do was smile and complete the project.

As CMS for Medicare and the State of New Jersey for Medicaid continue to make reimbursement a fully prospective payment system, there are still many reimbursement opportunities worth millions of dollars that are attainable to hospitals. Completing an accurate S-10 can be worth millions of dollars because of the sophisticated Charity Care recording process. Bad debts, interns and residents, OP Medicaid cost and DSH reviews can make a huge difference in the bottom line for a hospital. Preparing accurate Medicare & Medicaid Cost Reports are key to optimizing the reimbursement dollars. Most costing factors are generated from the Medicare Cost Report. Preparing an accurate Medicare Cost Report will enhance the ability to make new healthcare financial goals a reality. A trained reimbursement professional should be able to recognize opportunity and utilize their background and skills to uncover not only the low hanging fruit but attain the big fruit at the top of the reimbursement tree.

About the authors

John Manzi is Vice President Financial Consulting Services with Panacea Healthcare Solutions and can be reached at Jmanzi@panaceainc.com. Mike Sabo is currently Sr. VP, Medicare Reimbursement Services with Cloudmed and can be reached at Mike.Sabo@cloudmed.com.

Monmouth Medical Center Manager's Meeting, 1980s

Employment Law Update: Do's and Don'ts for Employers on Mandating COVID-19 Vaccinations

Maja M. Obradovic

Jemi Goulian Lucey

by Maja M. Obradovic and Jemi Goulian Lucey

Amidst the FDA's recent approval of at least two COVID-19 vaccines – and given the divergent views as to who will be able or willing to receive them in the coming months – employers are now considering whether and to what extent they can mandate vaccinations of their employees. Some clarity as to these much-debated issues was provided in the form of Equal Employment Opportunity Commission (EEOC) COVID-19 guidance issued on December 16, 2020.

The guidance pertaining to vaccinations is supplemental to the EEOC's existing COVID-19 guidance for employers, which was first issued in March 2020. The latest guidance focuses primarily on the intersection between a vaccination mandate and the Americans with Disabilities Act (ADA), the Genetic Information Nondiscrimination Act (GINA) and Title VII of the Civil Rights Act of 1964 (Title VII).

As an initial matter, the EEOC guidance clarified that being vaccinated is not considered a "medical examination." Simply by administering the vaccine to protect employees from contracting COVID-19, employers are not eliciting information regarding employees' health status or performing a medical examination. However, pre-screening questions, which per CDC guidelines may be necessary to ascertain whether there is a medical reason preventing someone from being vaccinated, can cross the line of the ADA rule prohibiting disability-related inquiries, as such questions are likely to seek information regarding an individual's possible disability.

One way for employers to avoid any possible violation of the ADA rule is to have a third-party unrelated to the employer (such as a pharmacy) ask the pre-screening questions and administer the vaccine. An employer can require that employees show proof they received the vaccine but should warn employees not to include any sensitive medical information in such proof.

Alternatively, if the employer is administering the vaccination directly, there are two options. One is to offer vaccination on a voluntary basis, which would in turn render any answers to disability-related questions voluntary. On the other hand, if employer-administered vaccination is desired to be mandatory – which is most likely to occur in the case of healthcare industry employers – the employer must show that any disability-related inquiry is "job-related and consistent with business necessity." This requirement is met if the employer has a reasonable belief, based on objective evidence, that the employee's refusal to answer questions and thus receive the vaccine poses a "direct threat" to the health of the employee or others.

There are two viable exceptions to a vaccination mandate, specifically based on (1) disability, and (2) sincerely held religious belief.

There are **two viable exceptions to a vaccination mandate**, specifically based on (1) disability, and (2) sincerely held religious belief.

If an employee is refusing to be vaccinated due to disability, the employer must demonstrate that the employee poses a direct threat due to "significant risk of substantial harm to the health or safety of the individual or others that cannot be eliminated or reduced by reasonable accommodations." In such a situation, the employer must evaluate whether the employee presents a "direct threat" by factoring in: (1) duration of the risk; (2) the nature and extent of the potential harm; (3) the likelihood of harm; and (4) how imminent is the potential harm. Ultimately, if the employee presents a direct threat to

the workplace, the employer must explore the options to accommodate the employee – for example, by allowing telework. Only if no reasonable accommodation is possible, can the employer exclude the employee from the workplace and, even then, before terminating the employee, the employer must consider whether other federal, state, or local laws provide additional protection.

The second exception from the vaccination mandate is based on the requirement that employers provide a reasonable accommodation for a sincerely held religious belief. Such accommodation is owed unless it presents "undue hardship," which under Title VII is characterized as more than a "*de minimis* cost or burden to the employer." Unless there is an objective basis for the employer to question the sincerity of the employee's religious belief, it is prudent not to question its genuineness.

Finally, it is important that employers avoid asking questions – especially during pre-screening – that may elicit an employee's genetic information in violation of GINA.

In sum, while employers can mandate vaccination, any such decisions should be carefully considered. It is essential that employers provide appropriate staff training to deal with any request for accommodations through a fair and structured interactive process. Also, any information relative to an employee's possible disability or request for accommodations must be kept confidential.

About the Authors

Maja M. Obradovic (mobradovic@greenbaumlaw.com) and Jemi Goulian Lucey (jlucey@greenbaumlaw.com) are partners in the Litigation, Employment and Healthcare Departments at Greenbaum, Rowe, Smith & Davis LLP. Ms. Obradovic co-chairs the firm's Employment Law Department, of which Ms. Lucey is a member.

•Who's Who in NJ Chapter Committees•

2020-2021 Chapter Committees and Scheduled Meeting Dates

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

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

COMMITTEE	PHONE	DATES/TIME/ ACCESS CODE	MEETING LOCATION
CARE (Compliance, Audit, Risk, & Ethics)			
Chair: Danette Slevinski – slevindl@uhnj.org	(516) 617-1421	First Thursday of the month	Conference Call
Co-Chair: Leslie Boles – lboles21@gmail.com	(732) 877-9864	9:00 AM	(712) 770-5393
Board Liaison: Lisa Maltese-Schaaf – LMaltese-Schaaf@childrens-specialized.org	(732) 507-6533	Access Code: 473803	
Communications / FOCUS			
Chair: Scott Besler (**Editor**) – Scott.Besler@atlanticare.org	(609) 383-2117	First Thursday of each month	Conference Call (712) 775-7460
Board Liaison: Brian Herdman – bherdman@cbiz.com	(609) 918-0990 x131	10:00 AM Access Code: 868310	In-person Meetings by Notification
Education			
Chair: Jane Kaye – jane@hcfadvisors.com	(732) 233-3144	Second Thursday of the Month	Conference Call
Co-Chair: Sandra Gubbine – Sandra.Gubbine@atlanticare.org	(609) 484-6407	9:00 AM	(712) 770-5044
Co-Chair: Hayley Shulman – hshulman@withum.com	(973) 898-9494	Access Code: 131556	
Board Liaison: Hayley Shulman – hshulman@withum.com	(973) 898-9494		
Certification (Sub-committee of Education)			
Chair: Amina Razanica – arazanica@njha.com	(609) 275-4029	Second Thursday of the Month	Conference Call
Board Liaison: Hayley Shulman – hshulman@withum.com	(973) 898-9494	10:00 AM Access Code: 131556	(712) 770-5044
FACT (Finance, Accounting, Capital & Taxes)			
Chair: Alex Filipiak – Alexander.Filipiak@rwjbh.org	(732) 789-0072	Third Wednesday of each month	Conference Call
Co-Chair: Spiro Leunes – sleunes@bdo.com	(917) 816-0601	8:00 AM	(712) 770-4952
Board Liaison: Dave Murray – murrayd@ihn.org		Access Code: 294782	
Institute 2020			
Chair: Mike McKeever – m.mckeever2@verizon.net	(609) 731-4528	Third Friday of each month	Conference Call
Co-Chair: Sandra Gubbine – Sandra.Gubbine@atlanticare.org	(609) 484-6407	10:00 AM	(712) 770-4957
Co-Chair: Jill Squiers – Jill.Squiers@AmeriHealth.com	(609) 662-2533	Access Code: 865290	
Board Liaison: Stacey Medeiros – Stacey.Medeiros@pennmedicine.upenn.edu	(609) 423-8731		
Membership Services/Networking			
Chair: Nicole Rosen – nrosen@acadia.pro	(862) 325-5906	Third Friday of each month	Conference Call (712) 770-5335
Co-Chair: John Byrne – JByrne56@gmail.com	(610) 737-6683	9:00 AM	In-person Meetings
Board Liaison: Heather Stanisci – hstanisci@ArcadiaRecovery.com	(862) 812-7923	Access Code: 267693	by Notification
Patient Access Services			
Chair: Daniel Demetrops – ddemetrops@medixteam.com	(845) 608-4866	February 11, March 11 & May 13, 2021	Aetna offices
Co-Chair: Jacqueline Lilly – jacqueline.lilly@atlanticare.org	(609) 385-3105	at 4:00PM	Parsippany
Board Liaison: Amina Razanica – arazanica@njha.com	(609) 275-4029	Access Code: 196273	Conference Call: (712) 770-5377
Patient Financial Services			
Chairman: Steven Stadtmauer – sstadtmauer@csandw-llp.com	(973) 778-1771 x146	Second Friday of each month	Conference Call (712) 770-4908
Co-Chair: Michael Berger – mberger10@comcast.net	(908) 794-8994	10:00 AM	In person Meetings
Co-Chair: Ruby Ramos – ruramos77@yahoo.com	(908) 884-7259	Access Code: 120676	by Notification
Board Liaison: Maria Facciponti – facciponti.maria@gmail.com	(973) 583-5881		
Payer/Provider Collaboration			
Chair: Michelle Merchant – Michelle_Merchant@horizonblue.com	(973) 466-4048	Third Wednesday of each month	Contact Committee
Co-Chair: Holly Fritz – holly.fritz01@aetna.com	(973) 244-3539	2:00 PM	
Board Liaison: Jill Squiers – Jill.Squiers@AmeriHealth.com	(609) 662-2533	WebEx	
Physician Practice Issues Forum			
Chair: Michael McLafferty – michael@mjmaes.com	(732) 598-8858	Third Wednesday of the Month	Wilentz, Spitzer & Goldman offices
Board Liaison: Erica Waller – erica.waller@pennmedicine.upenn.edu	(609) 620-8335	8:00AM In person with call in available	90 Woodbridge Center Dr
		WebEx: https://mjmadvisoryandeducationalservicesllc.my.webex.com/meet/michael	Woodbridge, NJ
Regulatory & Reimbursement			
Chair: Jason Friedman – Jason.friedman@atlantichealth.org	(973) 656-6951	Third Tuesday of each month	Conference Call (712) 770-5354
Co-Chair: Chris Czvornyek – chris@hospitalalliance.org	(609) 989-8200	9:00 AM	In Person Meetings
Co-Chair: Christine Gordon – cgordon@virtua.org	(856) 355-0655	Access Code: 382856	by Notification
Board Liaison: Scott Besler – Scott.Besler@atlanticare.org	(609) 383-2117		
Revenue Integrity			
Chair: Tiffani Bouchard – tbouchard@panaceainc.com	(651) 272-0587	Second Wednesday of each month	Conference Call (712) 770-5021
Co-Chair: Jennifer Daniels – jdaniels@panaceainc.com	(651) 424-4233	9:00 AM	In Person Meetings
Board Liaison: Jonathan Besler – jbesler@besler.com	(732) 392-8238	Access Code: 419677	by Notification
CPE Designation			
Chair: Lew Bivona – lewcpa@gmail.com	(609) 254-8141		
CLE Designation			
Chair: Michael P. McKeever, CPA – m.mckeever2@verizon.net	(609) 731-4528		

Ransomware: What CFOs Need to Know and Do

Annice Ma

Leanne Gallagher

by Annice Ma and Leanne Gallagher

Possession of sensitive patient information and the urgent nature of health services has, for many years, made health care entities a prime focus of cyber-attackers. The heightened cyber threat environment during the COVID-19 pandemic has continued to cement the health care industry as one of the most targeted by cybercriminals.

The US health care sector was among the top three industries attacked during the third quarter of 2020. This concerning trend was further underscored when the FBI, the Department of Health and Human Services (HHS), and the Cybersecurity and Infrastructure Security Agency issued a joint advisory in October warning about "an increased and imminent cybercrime threat" to US-based hospitals and health care providers.

Ransomware attacks against health care entities are typically perpetrated by sophisticated and persistent cyber criminals who tend to exploit three main criteria:

- Growing supplier vulnerability. The pandemic forced a rapid move to telehealth for remote patient care. Many health care organizations have affiliated with third-party telehealth providers, at times without sufficient time to engage in critical vendor risk management processes. As organizations grow their supplier ecosystem, it becomes increasingly important to emphasize proper data security vetting procedures and contractual controls, especially when a vendor has access to protected health information (PHI) and/or can connect to an organization's network.
- Expanded attack perimeters. Not only do IT professionals need to safeguard standard technology platforms, but they also need to ensure proper protections and access controls are in place for connected medical devices that are increasingly being used by hospitals and others which could be compromised and/or used as entry points to larger networks. Once in an organization's system, an attacker may move laterally across connected devices, further exploiting any access vulnerabilities. This threat is only expected to increase: The number of connected medical devices at an average facility is expected to jump from today's 20% to 70% within five years.
- Industry consolidation. Health care organizations going through mergers and acquisitions may face challenges when integrating disparate networks with different levels of security, especially when legacy systems can no longer be upgraded or patched. Cyber-attackers can attempt to evade detection by new or merged information security teams whose primary focus may be the integration of incompatible networks, devices, and software, taking away time from endpoint protection. While hospital mergers may lead to reduced operating costs per admission, the health care industry's high consumer churn rate – 7% – following a data breach makes the inclusion of cybersecurity risk analysis in corporate due diligence a crucial best practice.

Take Steps to Minimize Risk

The negative effects of a ransomware incident or other cyber-attacks on patient care and safety undoubtedly remain a primary concern for health care entities. However, cyber-attacks can also bring serious financial and organizational ramifications — including extortion payments, breach management expenses, regulatory fines and penalties, reputational damage, and potential medical malpractice risk. That's why it's important for health care organizations to start taking action before an attack to diminish the likelihood of the attack's success.

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Among other steps, health care organizations should focus on:

- Workforce education. Since phishing emails are among the most common tactics used by hackers to gain entry to networks and systems to access data and to deploy ransomware, it is important to train all employees to detect phishing emails and avoid opening potential malicious web links and/or attachments.
- Practicing good cyber hygiene. It is important to carry out regular data and system audits, and close or limit access to any Remote Desktop Protocol ports that are not in use or not essential. Implement multifactor authentication for network, system, and data access, paying particular attention to the most critical resources, such as protected health information (PHI) and health information technology (HIT) systems and applications.
- Backing up critical data. Protected backup data plays an important factor in determining whether certain critical systems can be restored in the face of network compromise. Backing up medical records on a daily basis, keeping encrypted offline copies that cannot be accessed from your operating systems of networks, and making sure you can quickly access your backup are paramount.

Health care organizations should foster a culture that underscores the importance of cybersecurity and protected health information, recognizing that these are fundamental to delivering quality care.

Prepare to Respond

Even the best risk mitigation measures may not be sufficient to avoid a cyber incident. Every health care organization should have a cyber incident response plan (IRP) that is regularly updated and tested. It is critical for the incident response team and senior executives to rehearse worst-case cyber scenarios through tabletop exercises where all stakeholders can practice their responses to specific cyber challenges. These exercises should help identify and address any gaps in a plan for response and mobilization before a real incident occurs.

Response plans should specifically address ransomware incidents, since these have unique characteristics, including threats to disclose PHI or other sensitive information. Knowing the location of each dataset is crucial, and can help organizations verify an extortionist's claims of data exfiltration and possession.

Response plans should identify the role of individual teams and how they would contribute to the response. Include an approvals framework to ensure prompt decision-making by appropriate executives. An IRP cannot be overly specific, since every ransomware or extortion incident is different. But a plan should outline key issues, including whether to pay the extortion demand and the time required to restore impacted systems and data. The plan should also identify key vendors to be engaged in the event of a cyber-attack, including outside counsel, forensics experts, extortion service providers, and public relations/crisis management specialists.

Since it is prohibited to pay funds to any person on the Specially Designated Nationals and Blocked Persons list published by the US Department of Treasury's Office of Foreign Assets Control, legal counsel should always be consulted regarding a ransom payment decision. Additional incident response specialists, such as notification and call center providers, should be identified to help an organization fulfill legal notification obligations in cases where PHI or personally identifiable information (PII) is compromised. Standard cyber insurance policies may require that insurers vet and approve vendors prior to engagement.

Understand Risk Transfer Options

Although we have seen health care entities invest heavily to bolster their cybersecurity, organizations should be aware that this does not guarantee protection from the financial and operational effects of cyber-attacks. Health care organizations should thus include robust risk transfer solutions in their cyber risk management efforts.

A cyber insurance policy can help mitigate the financial implications of a ransomware attack. Beyond an extortion payment itself, a cyber insurance policy can account for costs and expenses within the following categories:

- Expenses associated with investigation and incident response. A typical ransomware event requires the involvement of multiple external vendors to identify the source and scope of the incident, negotiate ransom demands with bad actors, facilitate any applicable crypto-currency payments, and restore or recreate any implicated data. Should data exfiltration take place — as is the current trend in ransomware attacks — an organization may also need to engage additional vendors to notify and provide credit monitoring services to affected patients and individuals.
- Business interruption losses. Beyond breach management expenses, an organization may also incur the loss of income or additional extra expenses to restore normal operations following a material interruption of its network. Health care organizations' growing reliance on critical technology and data make them increasingly susceptible to business interruption losses, and operational downtime from a ransomware event is growing exponentially.
- Third-party expenses associated with lawsuits and regulatory actions. Liability claims from affected patients could also ensue, along with fines and penalties assessed from regulatory bodies for data privacy violations.

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Navigating COVID Changes and Challenges as an Organization

Laura Hess

by Laura Hess, FHFMA

COVID turned our world upside down this year. Businesses were forced to adapt quickly, especially in healthcare, those on the front lines that did not have the opportunity to shutter their doors. Hospitals, physician practices and the many vendors that support them were forced to find solutions to challenges fast in order to continue to carry out their missions.

Many organizations moved staff to remote settings within days, had to identify new hires to fill gaps, and develop new protocols to get the work done. I took the opportunity to speak to several organizations to find out exactly what they did to adapt, and what was successful as well what maybe didn't work so well. Read on and perhaps you'll decide to try something new, or maybe you'll be inspired and awed by the resiliency!

But first, many thanks to the organizations and their professionals that took the time to share their experiences with me: HBCS' Maureen DiEleuterio, Vice President Talent Management & Development; Stephen Wing, Vice President, Operations; Joseph Dudek, Vice President Sales and Marketing; AtlantiCare Talent Acquisition Manager, Catherine McDonnell; and Regional Cancer Care Associates (RCCA) VP of Human Resources, Tammy Hopson.

What adjustments did you have to make quickly to move your staff remote?

Atlanticare: AtlantiCare, like many organizations, had recognized the benefit of allowing employees to work remotely either partially or full time and was slowly working toward offering a more robust Telecommuting program as an organizational strategy and initiative. We had started piloting this in different areas prior to COVID-19 and were going to evaluate the successes and opportunities for improvement in order to fine-tune the process.

When COVID-19 hit, circumstances accelerated these efforts and we had to expand implementation. The areas that were piloting or already working remotely before the pandemic significantly increased their frequency. Areas where employees were not working from home immediately transitioned to remote access.

To help with this initiative, the organization provided laptops where applicable. Our phone system has a capability to have office phones transferred to other phones or home phone. Our IT department worked quickly to grant capabilities that allowed employees to access their desktops virtually and educated employees on how to access different mediums. Being able to access the desktop virtually allowed employees to work effectively and securely via online software and security applications. We were also able to purchase and quickly implement licenses for videoconferencing tools to allow us to hold meetings virtually.

HBCS: Our existing disaster recovery strategy includes plans for deploying key staff quickly in the event of unforeseen events. So, we had a tested game plan in place long before COVID-19. Obviously, the fact that we had to transition 100% of our employees to remote status and maintain them on this remote status for a very extended period tested the strength of that game plan. Aside from the obvious logistical challenges of providing computer equipment and testing home internet access for our entire workforce, we also had to quickly identify and restructure all work processes that required on-site presence, such as certain printing and mailing functions, work processes that depend on physical files housed in our offices, and certain IT-related functions, so that there was no decline in any of these processes.

RCCA: RCCA was fortunate in that we had a leg up in telecommuting. We have had many employees working remotely for some time. We did find that our challenge was being able to obtain enough equipment – laptops and computer chips – to move the rest of the staff to remote quickly. This equipment shortage was something we had been dealing with before the pandemic hit though, and the pandemic definitely worsened the situation. We then had to coordinate people coming into the office to pick up desktops. Having enough equipment was definitely the issue for us.

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What are some of the challenges you have had to overcome?

AtlantiCare: Some of the setbacks we had implementing this goal, despite employees asking to work from home, was that some managers and directors were concerned about efficiency. They questioned how we would measure productivity. We sought guidance from leaders who had experience with employees working remotely. They shared best practices and served as a resource for the managers of the newly remote areas. We had to get beyond outdated points of view including "We always did it this way," and "It has to be in person or in the office – not both." We had to figure a way to help managers communicate effectively in a remote setting.

We experienced budgetary challenges – including unexpected needs for additional and/or expanded licenses and equipment. We also focused on maintaining our organizational culture in a virtual setting and keeping our employees engaged. Some departments implemented touch base calls or virtual meetings. These were a way leaders shared organizational updates and allowed the team to share any news, personal or work related information. Leaders and staff found these times to get together informational, motivational and supportive on so many levels.

One of our most successful communications initiatives has been our Virtual Town Halls. Lori Herndon, president and CEO of AtlantiCare, and Manish Trivedi, MD, division director, Infectious diseases and chair, Infection Prevention Committee, AtlantiCare regularly hold virtual meetings that open to all staff. These meetings have been a way for us to share real-time information and answer staff's questions and concerns. Additionally, we created a Coronavirus Central location on our intranet to give staff and providers a central location for all information about COVID. Staff could easily access information ranging from clinical to HR to support services. They could also access recordings of the Town Hall meetings if they were not able to attend live or wanted to listen again.

We featured staff prominently in our AtlantiCare's Got This campaign. We featured stories, photos, video and more in internal communications and external communications – including on social media and with traditional media.

Key to caring for our community during COVID-19 has been caring for our staff and providers.

Frequent, regular, proactive communication with staff and providers throughout COVID-19 was essential to keeping our patients, staff and community safe. Acknowledging that people will gravitate to channels with which they are most comfortable, we shared information in many ways.

- We added a Coronavirus-Central resource section to our intranet.
- We hold regular organizational leadership (ranging from daily to weekly) huddle calls, email leaders a summary of the huddle, and post the summary to Corona-virus Central.
- Again, we have our very successful Virtual Town Hall meetings. These events gave us another opportunity to get feedback from providers and staff and to answer questions and address concerns.
- Our Incident Command Center team has rounded with hospital staff daily, including for night and weekend shifts to answer questions and address issues. Additionally, leaders from throughout the organization have rounded in-person and virtually.
- Through our Resilience in Stressful Events or RISE program, we have provided 24/7 support to AtlantiCare providers and staff. RISE offers one-on-one assistance from department and unit leaders and trained peer supporters. The team refers staff to professional support and guidance, including through our employee assistance program, chaplains, social workers, and clinical psychologists.
- A licensed clinical social worker has led Mindful Monday virtual sessions that we have taped and shared on our Intranet.
- We have increased our Schwartz Rounds to encourage discussion among staff and providers and held weekly grateful gatherings to celebrate how the team and patients have overcome challenges.
- Our internal and external communications campaign – AtlantiCare's Got This – fostered employee engagement and joy in the workplace. This provided staff an opportunity to express themselves and gave the community a voice to show gratitude and support while adhering to infection prevention and other safety guidelines.
- We opened childcare and assistance with remote education options for employees; continue to distribute food to staff in need; hold virtual support groups as needed/requested; and regularly message to staff and providers services our Employee Assistance and other programs offer them and their families.
- We have honored all healthcare heroes through a Celebrating Our Frontline Heroes video tribute and photography display. The AtlantiCare Foundation's Healing Arts program talked with more than 30 providers and staff about how they have continued to provide care throughout the COVID-19 pandemic. The photos are on display in our hospital campuses.

HBCS: While a key expectation of the modern workforce is flexibility in work location and work scheduling, another key expectation is strong connectivity, not only from a technology

perspective, but also connectivity and access to the organization and the people within the organization. Literally overnight, our front-line managers and supervisors had to master the art of managing remotely; becoming proficient in new online meeting tools, instant messaging and team chat rooms, to ensure a continued human presence while coaching and developing their staff members.

As a company, we've also reinvested our employee engagement and communications methods. Company-wide virtual town hall meetings are common occurrences. We've incorporated creative alternatives such as online gift cards, award catalogues, and points-based games and contests to replace employee anniversary awards and other milestone events and activities that previously took place on-site. Incorporating telemedicine into our employee benefits strategy has also proven to be a very popular, time-saving and cost-saving option, particularly when employees could not easily schedule in-office medical visits.

RCCA: We find we are dealing with day-to-day struggles. Many employees are dealing with homeschooling their children who are remote learners now. These employees may be working non-traditional hours to get everything done. Many start their work day very early and finish later in the day. We have learned that you don't need everyone in the office though, and plan to leave our employees at home, enabling us to give up some of our office space.

Our finance department also successfully pushed many vendors to go electronic in their remittances, because otherwise someone has to get the mail!

At the practice level, many weren't comfortable with coming back into the office, so staffing at the clinic level has been a challenge.

Workers Comp has also been a big struggle. How do you determine if a provider caught COVID from seeing patients or just through everyday life? Now you have a sick provider and a long, drawn out workers' comp process while they do an extensive review, and how do you pay this person in the mean time?

COVID has made the nursing shortage even shorter. We have lost employees because they have lost their child care and had to resign to care for their families. We had one nurse on maternity leave and she was not able to return because she lost both of her parents to COVID, and they were the ones planning on taking care of the baby when the nurse went back to work. Another employee lost nine family members. How do you deal with that kind of tragedy?

The emotional toll has definitely been the worst. Every day is an emotional rollercoaster with stress and emotional struggles. We have beefed up our EAP program to help, and work hard to keep morale up and positivity across the board. Obviously, there was no Christmas party this year, so we did things like an employee appreciation week.

We have learned that as far as the business end of COVID goes, flexibility is the key.

How do you monitor productivity?

AtlantiCare: With the installation of virtual applications, we are able to see when employees are logged on to their computers. We also measure by assessing work accomplished and goals met. Continuous communication helps with productivity by keeping employees engaged and giving them the opportunity to express any concerns or challenges they are experiencing.

We implemented guidelines to ensure we were maintaining safety precautions and evaluated the impact these had on deadlines and goals.

HBCS: Monitoring productivity of remote employees is best achieved with a combination of workforce technology, quality performance measurement, transparency, and collaborative feedback. HBCS uses a combination of speech, desktop and text analytics capturing valuable metrics towards daily, weekly, and monthly balanced scorecard providing transparency to team members and management. = Key measurements are established based on employee job profiles and adjusted based on data trends. Daily communications through video, chat and instant messaging is essential to creating a positive morale, building connections, and ensuring optimal quality and productivity for remote teams. Further, a collaborative environment reduces miscommunication and establishes accountability.

RCCA: Our billing system already had A/R "thermometers" in place, so no changes were necessary for us here. Even when onsite, task queues are automatically set for each employee daily through our billing system where managers can monitor productivity.

Have you changed your hiring processes? If so, how?

AtlantiCare: Yes, our hiring process and practices have changed in that we are using more virtual interviews. Previously we invited our employees to our Human Resources offices to take their photo for their employee badge. We are now limiting the locations where this process is being done. We are holding virtual orientations and trainings unless it is imperative that people be onsite. In those cases, we follow strict safety guidelines for prevention of spread of COVID.

HBCS: Transitioning to a remote workforce model, whether in response to a pandemic or simply to meet the expectations of the modern workforce, has changed our approach to recruiting talent and onboarding new team members. It has allowed

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us to cast a much broader net for candidate searches, which also means more resumes and applications that need to be evaluated. Integrating AI tools into our candidate screening process has made that process much more efficient and effective. Video interviews and online testing tools have proven to be a timesaving and cost-effective alternative to the prior in-person process, with improved hiring results.

We have transformed how we onboard and train new virtual employees. Employee handbooks and training manuals have been replaced with digital resources. Our previous classroom-based training and orientation curriculum is now a coordinated program of webinars, online coursework, virtual job-shadowing, hands-on work simulations, and real-time call and account work in an online, proctored environment. Using technology and creative problem solving has ensured new team members transition smoothly and productively into their new roles.

RCCA: We changed our interview process to a virtual one but have not hired people out of our geographic regions as some commuting to the office is still necessary for new employees to obtain equipment and complete any required training. Shipping just didn't seem to work. We had a problem with things breaking in transit.

How do you determine pay rates with different geographic locations?

AtlantiCare: For our employees working remotely from other geographic locations, we have used experience and market data to determine pay rates.

HBCS: To determine appropriate pay rates for varied geographic locations, we evaluate the local cost of labor in each area, as well as the local market pricing for each specific job. While many organizations attempt to set geographical pay differentials based on "cost-of-living" differentials, these differentials only reflect the supply and demand for certain standard expenses such as consumables, healthcare, taxes and transportation. "Cost-of-labor" indicators more accurately reflect the supply and demand of labor across all occupations and industries within a geographical location and, when coupled with job and industry-based market pricing, provide us with an accurate picture of where we need to set our pay rates to be competitive in a given geographical area. Ultimately, our experience recruiting in a specific geographical market provides us with the clearest understanding of the expected pay rates for quality talent.

RCCA: We have not hired employees out of our current geographic locations.

Have your sales and client management staffs had to change their processes?

AtlantiCare: As we followed the safety measures, protocols and directives aimed at preventing spread of COVID, we quickly made so many changes. From enacting and enforcing safety measures to supporting patients, their families, our community and providers and staff, we had to work and communicate differently. We had already been offering telemedicine services in our hospital's Mainland campus for patients at risk for diabetes or diabetes complications. We have since ramped up our telemedicine program. Our Access Center team served as the point for all coronavirus calls. This included their activating a COVID hotline. Below are our call volume numbers.

Access Center Total Call Volume	Jul	Aug	Sep	Oct	Nov
2019	61,918	57,830	56,966	60,680	51,952
2020	64,167	54,594	59,788	64,419	65,526
% of Change	4%	-6%	5%	6%	26%

Our approach to care has long been that we care for all people with the same commitment and compassion as we would our own family members. Throughout the pandemic, staff from throughout AtlantiCare have truly had to serve as extended family members due to visitor policy updates aimed at preventing spread of COVID.

HBCS: Sales, marketing, and client management processes have evolved to deliver results through the pandemic. In-person access has been limited given the COVID-19 challenges healthcare providers face. While most meaningful sales activity is normally delivered through face-to-face interactions, virtual meetings have become the new normal. We've launched more digital marketing initiatives to contribute thought leadership in the RCM space.

Client management remains a focus for HBCS as client and patient satisfaction drive our success. Performance reviews and process management discussions continue as usual with the only change being the virtual delivery system versus in person meetings. Additional tools have been deployed to facilitate distribution of business trends, inventory analysis and various customer designed process KPIs.

RCCA: We have found that more outreach is needed during the pandemic. Current patients are not a problem as they continue to follow their treatment plans, however, we are finding that new patients are reluctant to start treatment.

We hope you enjoyed learning about how some of our fellow colleagues and organizations have quickly and successfully changed their operations in order to navigate the new COVID landscape. There is no doubt that the adaptability of those in healthcare is inspiring, and that they are true heroes.

About the author

Laura Hess is the Chapter Administrator for the New Jersey HFMA Chapter as well as a Search Consultant with Global Recruiters Network, a Forbes top ranking executive search firm. Laura successfully transitioned into recruiting in 2015, and is consistently ranked as a peak performer. Laura has many repeat customers and is often sought out by clients because of her personal understanding of the healthcare finance industry, her extensive network, and her exceptional ability to recognize top performers. Laura can be reached at NJHFMA@aol.com.

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It is, however, imperative for organizations to understand any policy requirements around incident notification, consent before incurring costs, and documentation. Although a cyber policy typically provides additional incident management resources, it's important to have a good understanding of what the insurer contemplates for coverage, and how to obtain consent for these services following an incident.

The health care industry remains one of the industries most targeted and disproportionately affected by ransomware. While cyber and ransomware risks cannot be completely eliminated, organizations can take appropriate measures to effectively mitigate, defend, and maintain financial protections against intrusion and the exploitation of critical data, systems, and networks.

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A Trip Through Institutes Past

Our winter issue of FOCUS traditionally includes a photo recap of our Annual Institute. Since we did not have the opportunity to meet in person this year, we decided to take a trip back in time, and reminisce on events past. We hope you enjoy this trip down memory lane!

From December 1996

20th Annual HFMA New Jersey Chapter Annual Institute
A State of Change

The financial, political and social transformation of the New Jersey healthcare industry

As part of the celebration of the HFMA's 50th Anniversary (not to mention the 20th anniversary of the Annual Institute), the New Jersey Chapter Annual Institute opened at the impressive Tropicana Casino and Resort in Atlantic City with a stellar lineup of speakers addressing the many changes facing the healthcare profession today. If you were not among the more than 200 chapter members to attend this gala event, sit back and let your fellow HFMA members bring you up to speed with a brief synopsis of the presentations.

Michael Wickett

Vision and Change

The opening speaker for the 20th Annual Institute provided insights into the changes in the healthcare profession and how to cope with those changes on an individual basis.

Illustrating the need for change and how change occurs, Mr. Wickett very ably introduced life-changing ideas into the healthcare environment. The best way to accomplish this is to stay positive, focusing on change as an opportunity rather than as a setback or deterrent.

When faced with change – you should ask yourself:

1. What could be *positive* about this?
2. How could this *benefit* me?
3. How can I use this situation to *improve* my future?

Simply stated, individuals should view change as an opportunity, with the following three key thoughts:

1. Use change to grow and thrive.
2. Develop a new written vision – list 100 life goals, professional as well as personal.
3. Stay positively focused each and every day.

> *"Life doesn't reward us for what we know; rather life rewards what we do."*

Change should be embraced as an *opportunity* for new levels of success and happiness. This was intertwined with interesting vignettes, either from his life or lives of others in which he has come into contact. Perhaps one of the more memorable thoughts was that jet pilots do not use rear view mirrors! Always look ahead; don't look back!

Marc Rodwin, Ph.D., JD

Medicine, Money and Morals

Professor Marc Rodwin, author of *Medicine, Money and Morals: Physicians' Conflicts of Interest*, addressed the topic of ethics in healthcare and specifically the managed care environment. Managed care was supposed to address the inefficiencies in the healthcare market. However, as Professor Rodwin points out, the drive to reduce expenditures may also eliminate desirable services and ultimately decrease the quality of life for some patients. In addition, by relying on standard protocols, complex cases may receive poorer medicine. It appears that the patient is getting lost in the equation.

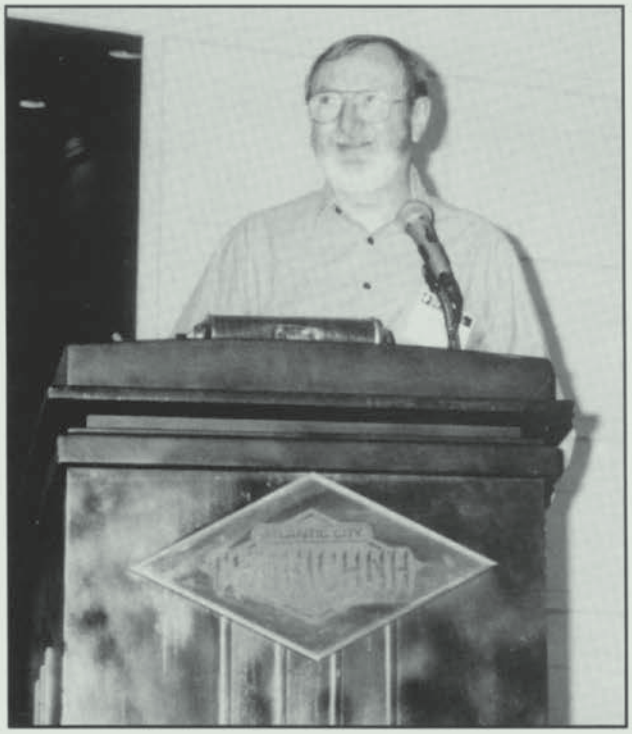
Within a managed care organization there are patients, doctors, case managers, administrators and third party payers. All have very different interests which may not always be compatible. The physicians are looking after the patients. However, they

A State of Change

Cathy Sullivan Clark discusses developing physician partnerships.

Charles Teasenfitz, Brian Sherin and Karen Mosner welcome Governor John Sununu to the Annual Institute.

Brian Sherin and Karen Mosner go over the program format with former Mayor of New York City, Ed Koch.



Art Ellerman accepts his 1996 Medal of Honor Award from the Chapter.

Jim Russell, Bill Fry and Joe Samples accept the Reeves Silver Award.

The Follmer Bronze Award recipients include Dick Bellows, Deborah Marsh, Sean Hopkins, Katie Gibbons, Dave Fulton, Enzo Archetti and Dave Mills.

Former Governor John Sununu addresses the program on Thursday.

Brian Sherin and Charles Teasenfitz outline the lunch menu with George Plimpton.

Mike Monahan and former Mayor Ed Koch at the conclusion of the program.

Michael Wickett provides insight on how to cope with changes in the industry.

may also be employees of the managed care company and therefore must serve the employer. Administrators have responsibility for the financial operations of the managed care company but also are responsible for the care of its members (the patient). Patients pay premiums and co-pays for their healthcare and therefore desire the best care possible. However, that level of care comes with higher costs. If the level of care goes up, then so would the premium and co-pays. Again a conflict arises.

This evolutionary process is still unfolding. Managed care companies are finding themselves being attacked by patients who feel their care was inadequate due to the involvement of the managed care company. It is not just the doctors who are being pursued to settle law suits. The government is being looked at to provide oversight even though the government was previously viewed as being too involved. The fast changing healthcare environment, including the consumers right to choice, will continue to impact the direction that managed care takes in the future.

Joseph Spinelli

Fraud & Abuse: Medicare and Beyond

"The cost of fraud today is ten percent of all healthcare dollars." This was the opening statement made by Mr. Joseph Spinelli.

Mr. Spinelli is a partner in KMPG's Forensic and Investigative Services practice for the Metro New York area. His responsibilities include concentrations in medical malpractice, Medicare fraud, Superfund cases, SEC fraud, embezzlement, corporate takeover, and antitrust. Prior to joining KMPG, Mr. Spinelli served as the first Inspector General under Governor Mario Cuomo for eight years. He also served as a Special Agent of the FBI for ten years.

Mr. Spinelli went on to explain that the U.S. Attorney General's office has made pursuing healthcare fraud its top priority, after violent crime. The government increased recoveries from fraud from $180 million in 1993 to $411 million in 1994, and the number of agents assigned to investigate healthcare fraud rose from 300 agents in 1994 to 450 agents in 1995.

Under a program named "Operation Restore Trust," the government will use the following to combat healthcare fraud:

- Civil Prosecution
- Criminal Prosecution
- Program Exclusion
- Whistle Blower (receive 30% of settlement)
- False Claims Act

The government increased recoveries from fraud from $180 million in 1993 to $411 million in 1994.

Typical areas to be looked at are "upcoding, miscoding, unbundling, and billing for services not medically necessary." Already, major fines have been levied on prestigious institutions and medical groups. The best known example of their efforts is the $30,000,000 fine against Clinical Practice of the University of Pennsylvania. Besides the fine, the Penn doctors agreed to an extensive compliance and disclosure program which includes "centralization of all billing and financial functions and revamping of internal procedures," among other restrictions.

Mr. Spinelli went on to what many listeners felt was the most important part of his presentation: "what an institution can do to limit their potential exposure." Setting up an effective "Compliance Program" can earn up to 95 % reduction in any penalties. Mr. Spinelli pointed out it is better to set up your own Corporate Compliance Program prior to having a problem identified than to have the government set up a program for you. The cost of setting up and operating your own program is a tax deductible corporate expense. An effective program also protects you from whistle blower programs because under this design, potential whistle blowers are required to report any findings to a designated representative of the company. Furthermore, employees should be required to sign a code of conduct yearly which makes it clear who they are to report to, and when.

Other steps that should be taken include:

- Adoption of a resolution by the Board of Directors authorizing the creation of a corporate compliance program.
- Supplementation of your corporate compliance program with a formal code of conduct.

Mr. Spinelli closed by making it clear that it's not too late for institutions to act upon this. No one should be waiting to see what is going to happen. As institutions, we need to be pro-active in the current fraud-focused climate.

Managed Care Panel

Medicare Risk Contracts - How Risky is Risk?

When the Institute Committee selected Medicare as the subject of the breakout sessions, Ms. Carol Thomas, President of the New Jersey Society of Managed Care Executives, was asked to be the moderator of the session on Medicare Contracting. The discussion panel included a representative of the Federal Government; Ms. Marcia Dashevsky, from the Philadelphia HCFA office; a Medicare HMO, Mr. Terence Cahill, Senior Vice President, First Options Health Plan; and a hospital provider, Ms. Nancy Taylor-Ward of the St. Joseph's/St. Anthony's Health Systems of Tampa, Florida.

As fate would allow, "Hurricane Lillie" intervened and Ms. Ward was unable to attend the Institute, but Carol Thomas, now with Health Partners, Inc. of Philadelphia, an HMO owned by eight Philadelphia Hospitals, covered the provider experience because she was the managed care director of Our Lady of Lourdes Medical Center in Camden, New Jersey.

Thus wearing two hats, both of the moderator and the provider, Ms. Thomas led off the discussion with a presentation on "Medicare Contracts - How Risky is Risk?" The presentation included the underlying assumptions of the Federal Government, of the HMO's and of the providers. Based on those assumptions, various goals were delineated. These goals are:

1. Efficient Use of Resources - Cost Containment
2. Efficient Use of Resources - Quality Assurance
3. Financial Reward - Profitability

All three have to be balanced by constituent satisfaction and the distribution of resources. If the assumptions were wrong, then the goals would be difficult to attain.

The panel then went into detailing the incentives and disincentives for cost containment, quality assurance, and profitability. Included in the discussion were the questions, "Can the infrastructure support the risk," "Can intangibles support the risk," and "What could the government wild card be?"

Adding to the discussion and question and answer period, the representative from HCFA, Marcia Dashevsky, indicated that as part of the provider's cost containment there will be a very labor intensive effort, specifically in the area of case management. Ms. Dashevsky also did not feel that the Federal Government will make enrollment in Medicare HMO's mandatory. There may be some government repricing to the HMO's due to the chronically ill being disenrolled from various HMO's and put back into the traditional Medicare plan.

Mr. Cahill, who was very open in his discussions, indicated that right now, HMO's are very sales oriented rather than managed care oriented, but once the enrollment targets are reached, managed care and cost containment will be a major thrust. Mr. Cahill stated that the traditional Medicare utilization ranges from 3,300 to 4,500 days per thousand population. The goal, however, for the HMO's is to bring that down to 1,200 to 2,000 days per thousand population. Because there is a major influx in the enrollment in Medicare HMO's from employers who have the liability for the supplemental plan for their retirees, growth and the reaching of enrollment goals will move at a faster pace.

Ms. Thomas, in concluding, mentioned that each of the entities-Federal Government, HMO's and providers-has a risk when contracting to put a Medicare product into a managed care setting. She likened the contracting to playing Russian roulette by stating, "the degree of risk is directly proportional to the number of bullets in the chamber."

George Plimpton

An Amateur Among The Pros

Urbane and articulate, author George Plimpton regaled the Institute's luncheon audience with tales of his exploits in several professional sports. Plimpton, who has degrees from Harvard University, Kings College and Oxford University, explained that he first began briefly entering other people's occupations while a student at Harvard. He wanted to join the staff of the Harvard Lampoon, but was told he could not unless he ran in the Boston Marathon. He did so, joining the race about three blocks from the finish line on Commonwealth Avenue, right on the heels of the leader, who couldn't figure out where this fresh runner had materialized from. Exhausted after 26 miles, the leader barely staved off Plimpton at the finish line. It was only after they were taken off to the press tent that it was discovered that Plimpton was an imposter.

Plimpton credited Paul Gallico, sports writer for the New York Daily News, with being the father of participative journalism. Gallico felt that it was inappropriate to write about professional athletes without understanding the challenges that they faced. During the 1930s, Gallico played golf with Bobby Jones and tennis with Bill Tilden, boxed with Jack Dempsey and caught Herb Pennock. Gallico went on to enjoy a successful career as an author.

After graduation, Plimpton joined the staff at Sports Illustrated magazine and pitched in a post-season All-Star Game at Yankee Stadium as background for an article he was writing. Much to his amazement, he began by getting Richie Ashburn and Willie Mays out, on "pop flies to the warning track." The next batter, Frank Thomas, hit Plimpton's next pitch well into the upper deck, ending what had been (until then) a promising pitching career. Plimpton elaborated on these experiences in his first book, "Out Of My League."

Not one to rest on his laurels, George Plimpton currently is preparing to sing in a performance of "La Boheme" at the Metropolitan Opera.

Subsequently, he joined the Detroit Lions and worked out at quarterback. Plimpton characterized professional football as more than just a contact sport, describing it as a "collision sport." He got in for one series during the pre-season, and

the Lions lost 32 yards in four plays. He depicted these experiences in more detail in "Paper Lion."

Plimpton boxed a three-round exhibition with light-heavyweight champion Archie Moore and was scheduled to box Muhamed Ali, whom he described as an extraordinary fighter, charismatic and forceful. Fortunately for George Plimpton, that bout was postponed and never rescheduled. Other sports appearances included point guard for the 1969 Boston Celtics, where he briefly replaced John Havlicek in a game against the Atlanta Hawks, and as goaltender for the Boston Bruins, where he had an opportunity to stop a penalty shot by Reggie Leach of the Philadelphia Flyers. Mr. Plimpton pointed out that, counting all the sports, there are a total of only 6,000 professional athletes in the country, and that he was pleased for the opportunity to gain a first-hand appreciation for their remarkable physical skills.

Surprisingly, Plimpton stated that his most terrifying experience occurred not in professional sports, but rather in playing percussion with the New York Philharmonic Orchestra under the direction of Leonard Bernstein. In music, once a piece is started, there's no room for a mistake. In professional sports, on the other hand, success often results from taking advantage of an adversary's mistake. "In music, when you make a mistake, you destroy a work of art," Plimpton said. He went on to describe the error he made when playing the triangle during a rendition of Mahler's Fourth Symphony played in London, Ontario. The error was immediately apparent to the entire orchestra, especially Maestro Bernstein.

Plimpton described the despair that ensued following the performance. The other members of the percussion section took him out afterwards, consoling him with their own favorite stories of percussionists playing errors which only served to exacerbate his already morose state of mind. Recognizing his plight, they also interceded with Maestro Bernstein, begging that he give Plimpton one more chance. The Maestro agreed, but only on the condition that Plimpton not attempt to read and follow the music, but focus his undivided attention on Bernstein, who would cue him at the correct moment.

The next evening, the Philharmonic appeared in Winnipeg, playing Tchaikovsky's Second Symphony (the Little Russian), with George Plimpton on gong. When Bernstein cued him in the fourth movement, Plimpton struck the gong so resoundingly that the musicians in the first row bounced. Subsequently, when the Philharmonic recorded this symphony, Maestro Bernstein invited Plimpton to strike the gong, and this rendition often is referred to as "the Winnipeg sound."

Not one to rest on his laurels, Plimpton currently is preparing to sing in a performance of "La Boheme" at the Metropolitan Opera. Judging from the applause that followed his conclusion, HFMA members found nothing fake about his presentation but rather a genuine appreciation of his accomplishments.

Cathy Sullivan Clark

Developing Physician Partnerships

Capitated payment systems are the fundamental basis for developing integrated delivery systems between strong physician networks and hospitals, according to Cathy Sullivan Clark, a Vice President of Jennings, Ryan, and Kolb, consultants of Hadley, Massachusetts.

In a Friday morning presentation, Ms. Clark stressed that the movement to capitation has pushed integrated delivery systems (IDS) to the forefront as the model best adapted to procuring the contracts that will insure future economic viability. However, she cautioned that integration is not without its risks and obstacles, highlighting potential problems in:

- selecting the wrong physicians:
- developing an adequate information support system;
- having adequate expertise to manage the network;
- alienation of physicians within and outside the network;
- investing significant funds with marginal return;
- integrating before market and payors are ready, thus focusing management's attentions from more critical current issues.

Having outlined the problems, Ms. Clark indicated developing an IDS now can reap large benefits for healthcare providers by permitting the "luxury" of moving along a learning curve and establishing market position in the probable event capitation becomes the norm. But the ultimate benefit will be development of a system which actively manages the quality and cost of care, a result that enhances any network's chances of adapting positively to whatever healthcare payment system predominates.

Developing an IDS now can reap large benefits for healthcare providers.

Cost and Quality Controls

Ms. Clark noted that cost control is the number one critical success factor under capitation, and physician integration is integral to achieving cost and quality control. She outlined some of the implications of physician integration, comparing the benefits (e.g. lock-in of existing physician services) and liabilities (physician-hospital "control" contest) of practice purchase versus recruiting of new physicians to an area.

Success in physician integration depends on several key factors:

- Significant supply of primary care physicians and physician extenders;
- Geographic distribution of service providers;
- Effective patient care management/ gatekeeper role;
- Integrated information management system;
- Outcomes quality/measurement program;
- Physician leadership.

Ms. Clark stressed the key role physicians will play in the success of any IDS, as the management of the medical component of the system is critical. Perhaps the foremost part of any IDS will be the primary care physicians who are at the front line, determining which specialists will be part of the IDS and insuring the development of a physician "eco-system" upon which the IDS can depend and thrive.

Physician-Hospital Organizations (PHO) were reviewed, and while a positive first step toward substantial collaboration between the hospital and physicians, they may not furnish sufficient benefits to warrant the considerable investments they necessitate and may not be able to compete with more advanced models in the local market.

PHOs have provided a way for Integrated Systems to develop by detailing the necessity of steps like procuring sufficient primary care physicians to serve as gatekeepers, signaling a change to selection of member physicians based on quality and cost criteria, and initiating a change in how care is provided.

Ms. Clark then outlined the benefits of Management Service Organizations (MSO) in permitting physicians equity in joint ventures and reducing overhead through economies of scale that can benefit non-owners who avail themselves of MSO services. The flexible structure of MSO enhances development of the multi-specialty groups that Ms. Clark indicated will be the natural vehicles for future managed care contracting. Multi-specialty groups where more than one specialty is represented share economic risk and thus accumulate and allocate capital in a manner designed to improve cost and quality of patient care to achieve efficiencies. While this type of group may reduce physician autonomy over office practice and compensation, it will establish a professional group management staff and achieve agreement on group goals, governance, and compensation. The ultimate result can be a committed physician leadership that will set a course for an IDS to grow by insuring quality services base on a cost-conscious infrastructure.

Governor John Sununu

The View from Washington

Governor John Sununu served as Chief of Staff to President George Bush from January 21, 1989 until March 1, 1992. In addition, he served three consecutive terms as Governor of New Hampshire commencing on January 6, 1983. Prior to this, Mr. Sununu had 20 years experience as an educator, engineer, small businessman and community leader. Together these experiences have shaped Mr. Sununu's point of view in terms of government's role in domestic and international affairs.

Although the Governor's presentation was originally billed as "A View From Washington," at the outset Mr. Sununu indicated that he would be deviating from this theme remarking, "who would want to hear about what is going on in Washington, anyway?" Instead, Governor Sununu chose to speak about the changing state of world affairs and the role that America should play. He specifically spoke of the current situation in Russia and how the new-fashioned free market economy is slowly changing the landscape of the late democratic nation for the better.

This raised a question from an audience member who asked just how well capitalism was working in Russia. This spurred an interesting, and somewhat emotional, mini-debate between the Governor and his questioner. Mr. Sununu's final point was that the economic changes in Russia have clearly been slowed due to the significant political obstacles that must be overcome concurrently with the incredible adjustments to the shift to a free market economy. However, capitalism ultimately will prevail.

Governor Sununu also made the point that, in the United States, it is often noted that politicians are not willing to make the "hard vote." However, he went on to say that it is not necessarily the politicians that must make the hard votes but the public themselves. That is, the public must ignore the trivial issues that often bog down political campaigns, vote for candidates based upon the real issues, vote candidates out who do not live up to their promises and demand more from their elected officials.

An unabashed advocate of the capitalist free enterprise system, Governor Sununu opined that "If anybody (i.e., Ross Perot) that stupid can get rich, it's a testament to the American economy."

The Governor further noted that this time in history will be one of the most significant in our nation's history. This era will not merely receive a paragraph in the history books but rather a full chapter or more. Asked about President Clinton's intentions in terms of healthcare legislation, Mr. Sununu indicated that he felt there may very well be additional initiatives on the

part of the Administration related to healthcare. He further stated that, based upon his past association with the President when Mr. Clinton was Governor of Arkansas, the President is more concerned about having his name associated with legislation than the content of the legislation itself.

Finally, when asked about Reform Party candidate Ross Perot and what he brings to the table in terms of the presidential election, the Governor did not mince words. Mr. Sununu responded that Mr. Perot gives hope to all of us; if someone like that can become a millionaire than there is hope for all of us to be able to do the same.

Dick Clarke

President and CEO, HFMA National

Dick Clarke, President and CEO of the National HFMA, addressed the attendees regarding the current and future direction of the organization. The overriding theme of Mr. Clarke's remarks was that the HFMA must, as is true of the entire industry, embrace change. The one comment concerning change that certainly stuck in the minds of those in the audience was: "If you have to eat a frog, don't look at it too long. If you have to eat two frogs, eat the bigger one first."

In accordance with his advice, Mr. Clarke mentioned two initiatives taken by HFMA. The first is HFMA's recent affiliation with the Medical Group Management Association (MGMA). The second is the facilitation of certification testing by utilizing Sylvan Learning Centers, nationally, as electronic testing devices.

Finally, Mr. Clarke noted our Chapter's accomplishments and, specifically, the high quality of the *Garden State Focus* magazine.

Warren J. Hern

Chairman of the Board, HFMA National

Warren J. Hern, Chairman of the Board, HFMA National was introduced by New Jersey Chapter president Chuck Teasenfitz.

Mr. Hern spoke briefly about the 50 years of HFMA, congratulated New Jersey on its 20th Annual Institute, and reminisced about his New Jersey roots. Perhaps he was also anxious to hear George Plimpton's luncheon address.

Chuck presented Mr. Hern with a commemorative brick from the Margaret Hague Maternity Hospital building (a.k.a. Jersey City Medical Center). Mr. Hern was born at Margaret Hague along with hundreds of thousands of other New Jersey natives between its heyday years of 1935 and 1965. During this period, the hospital had 1,000 maternity/nursery beds.

Mayor Edward Koch

Societal Considerations in the Delivery of Healthcare

The program concluded Friday morning with the final speaker, former Mayor of New York City, Ed Koch. Mr. Koch began his presentation focusing on the societal concerns of healthcare, such as AIDS. He also briefly addressed the many concerns of the elderly regarding healthcare and healthcare coverage. The Mayor stated that he, too, had concerns, being over 65, on Medicare and recently having had a mild stroke.

Mr. Koch noted that our jobs aren't easy, and he has experienced that first hand. As mayor of New York City, he was responsible for the New York City hospitals, (15 of them) during his administration.

Mr. Koch ended his presentation with a question and answer period that covered a wide range of topics from his book and radio show, to the New Jersey elections and whether or not the New York Yankees will move to New Jersey. The dynamic individual that he is, he volunteered to have his picture taken with any attendee who was interested.

Koch was the only three-term Mayor of New York City to run for an unprecedented fourth term, losing to David Dinkins, who became the city's first Black mayor.

Asked his opinion of his successors, he described Dinkins as "a nice guy, but a terrible mayor." He supported Rudolph Giuliani, "a good mayor, but a terrible guy," noting that Giuliani "has a cop's mentality and, to be mayor, you have to be more than a cop."

Thanks to Institute Committee members Garry J. DeLeeuwerk, Sandra M. Roth, Rosann Rizzuto, James E. Russell, Richard J. Bellows, and Jeffrey L. Weinstein, and Publications Committee members Gabby Parseghian, Peter J. Hughes, and John Dalton for their contributions to this article. In addition, we would like to thank all the hardworking members of the Institute Committee for this year's very successful Annual Institute.

From December 1997

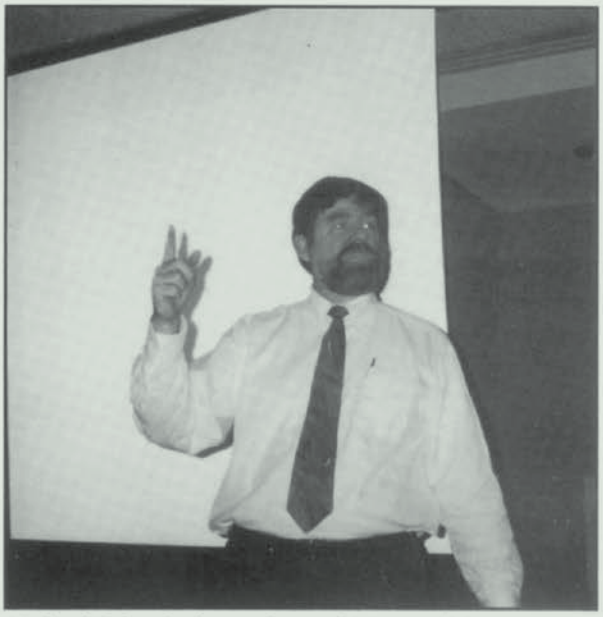
Annual Institute 1997

Lisa Silver, John Manzi, JaneAnn Sheehan, Mike Rachmiel

Tom Shanahan, Joe Lemaire, Rick Parker, Tom Scott

Greg Adams, Stella Visaggio, Katie Gibbbons, Theo Tamborlaine

Greg Adams, Kathy Mann, Gary Mann



Michael Schatzki from Advanced Managed Care Contracting

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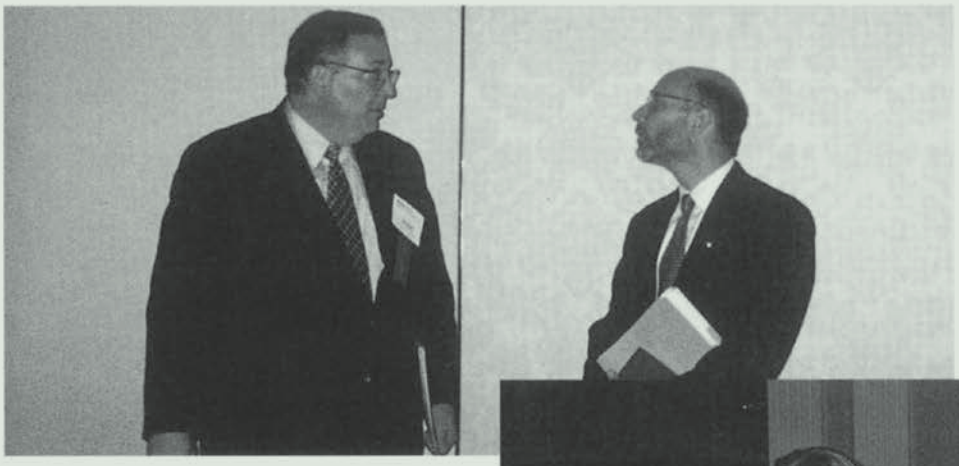

Bruce Vladeck and Len Fishman

Stella Visaggio, Peter Allen and Gabby Parseghian

Gary Mann, Kathy Mann and Charles Santangelo

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Sean Hopkins and Cheryl Cohen

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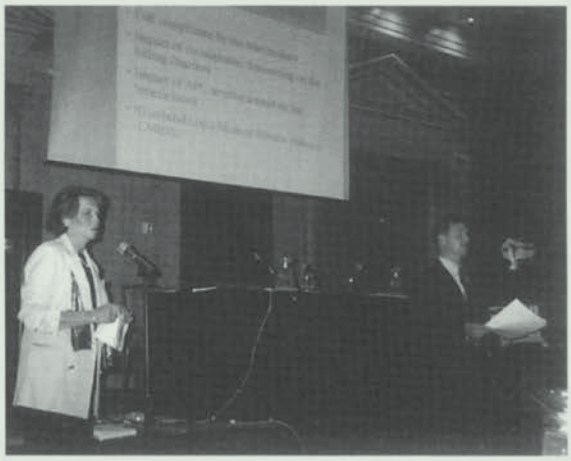
2000 Institute a Success

Panel on capital discussion: From left to right: Dennis Doody, Edith Behr, George Popko, Liz Sweeny, Gary Carter, Pamela Federbush, John Chyriwski, Tom Dwyer



CBIZ: Jane Anne Sheehan, George Kelly

E-Commerce panel: From left to right: Sean Hopkins moderator, Dennis Doody,MC at Princeton, Bill Baroni, Esq., George Popko, Cathedral Healthcare, Gail Hinte, Cisco, Gary Carter, NJHA, Marvin Gozum MD, Jefferson, Dave Cote, Healthcon/WEBMD

Gail Hinte

CFO's from left to righ: Gary Deleuwerk, West Hudson Hospital, Tom Shanahan, Clara Maas MC, Paul Rouvel, Kimball Medical Center, Dennis Roemer, Cooper Health System,

From left to right: Tom Shanahan, Rita Romeu, Stuart Altman, Cheryl Cohen

Institute Draws Record Registration

by John J. Dalton, FHFMA

The 26th Annual New Jersey Institute surpassed 2001's record shattering Silver Anniversary Institute, attracting 323 registrants with its theme of "Look Before You Leap: Trends and Challenges." The Institute opened Wednesday evening with a well attended "Parrot Heads & Paradise" vendor fair, followed by "Margaritaville," a networking social that featured limbo and hula hoop contests. Most attendees dressed in accordance with the spirit of the event. Best costume winners were Sandy Puerta with honorable mention to Joe Samples and Gabby Parseghian.

Keynote speaker, futurist Russell C. Coile, Jr., provided the Thursday morning wake-up call for attendees with his dynamic address, "Healthcare 2010: the Challenges of Capacity, Capital and Competition." For the last ten years, his annual "top 10" predictions for the health care field have been 90% accurate.

Quoting New Jersey's internationally renowned philosopher, Yogi Berra, Coile noted, "The future isn't what it used to be." The lines between HMOs, PPOs and POS plans have blurred. This represents a significant victory for consumers, who voted with their feet, and a window of opportunity for providers prepared to respond to consumer-driven health care. Coile stated: "A fundamentally new model is needed if America's voluntary health system is to survive in the Millennium. Shifting the model from risk-avoidance to risk-management could turn the health industry from an illness-intervention paradigm to health promotion." In Coile's view, healthcare's new paradigm includes the following elements:

- Customer-centered;
- Information empowered;
- Patients as partners;
- Ambulatory/hospital in the home;
- Prevention and promotion;
- Pharmacology and lifestyle;
- Complementary medicine;
- Facilities designed for healing; and
- Faith, spirituality and well-being.

Roger Enis, Barbera Radey, Paul Porter, Staci Costine

Beyond Managed Care

Healthcare in America now is moving beyond managed care. Providers have rejected risk capitation and are demanding and getting better payment rates. Consumers have rejected gatekeepers and prefer PPOs and point of service plans. Managed care doesn't have a new business model, and HMOs market power has waned. With the information explosion on the World Wide Web, consumer choice has entered the provider selection equation as never before.

More than 100 million consumers use the Web for health information, and most are Boomers and/or women. Despite the information explosion, half of patients with chronic conditions are non-compliant with their prescribed medication regimens. Getting five star ratings and "Best 100 Hospital" rankings are becoming an integral part of attracting consumers.

From 1990-2000, U.S. population increased by 32.7 million to 283 million. This is the largest ten year population gain ever recorded, and 40% of the increase was due to immigration. The 1990's also were a period of under investment in health care facilities. As a result, hospital occupancy rose to 76%, and 66% of Emergency Rooms are at or over capacity. The challenge to providers is managing growth as volumes increase.

Coile expects that this decade will see dramatic increases in facility spending, with a focus on niche hospitals (e.g., heart hospitals, women's hospitals, children's hospitals, cancer centers, etc.), as well as ambulatory care, surgical and diagnostic centers. There will be marketing wars for services and for insured patients.

John Barone, Greg Adams, Gabby Parseghian

Radical changes in clinical technology, including genomics, gene therapy, minimally invasive surgery and the like could lead to a revival of the "medical arms race." Quality and safety concerns are not limited solely to the Leapfrog initiative. The Institute of Medicine report, "To Err Is Human," estimated that 44,000-98,000 patients die annually as a result of medication errors, and that these preventable deaths add $17-19 billion to healthcare expenditures. With a touch of irony, Coile noted that increased efficiency coupled with quality improvement could produce added capacity without having to build.

Labor shortages in nursing, pharmacy, radiology, anesthesiology and pathology are expected to last through the decade. Coile forecast that there will be a massive shift from Medicaid to providers, and urged listeners to follow the universal coverage debates in Maine and Oregon, noting that both are physician led.

Competition Based on ....

During this decade, hospitals will compete on a variety of bases, including excellence, quality, design and

(continued on page 12)

Rita Romeau, Sean Hopkins

Tom Shanahan, Marc Valuck

(continued from page 11)

world-class service. Coile cited Chicago's Northwestern Memorial as an example of a "peak performer" hospital that competes on excellence. He also pointed out that competing on price is a wholesale strategy while competing on quality is a retail strategy. Hospitals that compete on quality benchmark performance versus best in class indicators, rely on evidence based medicine to reduce medical errors and improve outcomes, and utilize the "Six Sigma" quality improvement model from Motorola.

Other hospitals compete by design, providing an environment that is welcoming to patients. Coile cited the Woodwinds Health Campus in Woodbury, MN as an example of a hospital that is patient sensitive, family centered, and conveys the ambience of a fine, small hotel. Pointing to Hackensack University Medical Center's introduction of the Nicole Miller line of hospital attire, Coile noted that providing world-class service was yet another effective way to differentiate hospitals. Hospitals that think customer, and learn from the Ritz Carltons, Nordstroms and Southwest Airlines are likely to have a sustainable competitive edge. Providing world-class service requires management and Board commitment and a pervasive, customer focused culture.

Coile concluded by looking to leadership as the key, suggesting that true leadership goes beyond the facility's bottom line to include the welfare of patients, the well-being of employees, building the community and financial health.

Competing on excellence includes elements of all of the above. These hospitals are both high tech and high touch. Many follow niche strategies, recruiting "star" physicians to become centers of excellence for certain service lines. They differentiate themselves from competitors based on service and quality, and continually market new technology and facilities. These are good hospitals that have become great hospitals. Many have attained Magnet designation from the American Nurses Association

Healthcare 2010

Coile then shared his vision for the future of American healthcare.

(continued on page 14)

Stella Visaggio, Cheryl Baker, Karen Mosner

John Dalton, Seymour Eagel

Susan Milnes, Greg Adams, Mary Ann Adams, Marie Swarctz

(continued from page 12)

"After five years of market turmoil and financial instability, America's $1.3 trillion health industry is settling into a millennium groove. Most indicators are trending upwards. Healthcare expenditures are rising, and neither managed care nor government seem able to slow down the rise in health spending." Coile presented three Futurescan scenarios:

1. Booming Business - In a high growth economy, demand for health services rises and health costs increase. Employees accept cost increases while business is good. Consumer satisfaction is high, even though patients must pay more out-of-pocket.

2. Lite Medicine - A mixed economic forecast imposes some financial constraints on healthcare from managed care and government. Providers respond with voluntary capacity reduction and provider cost controls, and health inflation remains modest at 4-5%.

3. National Health - A low-growth economy and rising number of uninsured leads the Federal government to intervene to provide affordable healthcare under a universal Medicare program. Providers dissatisfied with managed care and struggling under the burden of uncompensated care welcome the shift to government financing.

The Futurescan survey was conducted in 2001 for the Society of Healthcare Strategy and Market Development of the American Hospital Association. While most survey respondents preferred the Booming Business scenario, they also rated Lite Medicine as the most probable.

To illustrate his vision for healthcare, Coile provided the following quote from "The Experience Economy," authored by Joseph H. Pine II and James H. Gilmore in 1999: "What consumers want is not a service or a product. They want an experience. Every business can be a stage, and every consumer encounter is theater. In the 'transformational experience,' the customers achieve their desired outcome, such as health, fitness, or spiritual growth."

Coile concluded by looking to leadership as the key, suggesting that true leadership goes beyond the facility's bottom line to include the welfare of patients, the well-being of employees, building the community and financial health.

John J. Dalton, FHFMA is vice President of Sales and Marketing for the Revenue Maximization Group Inc. in Eatontown. He was the 2001 winner of the Frederick C. Morgan Award for lifetime achievement in healthcare financial management.

(More photos on page 16)

Roger Sarao, Kevin Lenahan

Tom Shanahan, Marc Valuck, Dotti Lindstrom

(continued from page 14)

Guy Evans, Tara O'Neill, Chiarina Fanara, Debbie Owens, Virginia Marcus

Dorothy DeLuca, Mike Monahan, Brian Fitzpatrick, Tom Scott

(More photos on page 18)

2002 Institute

Winners:
Pete Allen - *Adirondack Chairs*
Lindsey Sutman - *Airline Tickets*
Mark Dougherty - *Vacation Giveaway*

Hula Hoop Female Winners - Heather Weber & Elizabeth Jennings
Hula Hoop Male Winner - Roger Ennis
Limbo - Staci Costine
Best Dressed - Sandy Puerta
Honorable Mention Best Dressed - Joe Samples & Gabby Parseghian

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Annual Institute Draws Record Registration

by John Dalton, FHFMA

Whether it was the warm Indian summer weather, the quality of the program content, or the networking opportunities that drew them, the 2003 Annual Institute shattered the all-time attendance record of 323 set just last year, with a total of 350 registrants. Held at Bally's Park Place in Atlantic City, the Institute opened Wednesday evening, October 8 with a vendor fair and a "Back to the '70s" networking social that gave early registrants an opportunity to meet other attendees. The room rocked until midnight, and many participants came appropriately attired with tie-dye T-shirts, mini-skirts and other accessories apropos to the time. President-Elect Rick Parker as Super Fly and Director Cheryl Cohen in disco attire helped to set the theme.

Thursday morning, Chapter President Stella Visaggio, Chief Financial Officer at Hackettstown Community Hospital, greeted the audience and thanked them for making the 2003 Institute New Jersey's most successful ever. She then introduced HFMA National Chairman David P. Canfield, FHFMA, who elaborated on his theme, "HFMA: It's Personal," noting that he never had to apply for a job or seek an interview, attributing this to the terrific networking opportunities that HFMA always has provided him.

Mr. Canfield then introduced the Institute's Keynote Speaker, Donna Shalala, current President of the University of Miami, and previously the longest serving Secretary of Health and Human Services (HHS) in United States history. Appointed by President Clinton in 1993, Dr. Shalala directed the welfare reform process, made health insurance available to an estimated 3.3 million children through the State Children's Health Insurance Programs (SCHIP), raised child immunization rates to the highest levels in history, led major reforms of the FDA's drug approval process, revitalized the National Institute of Health, and directed a major management and policy reform of Medicare. Prior to her appointment as Secretary of HHS, she had served as president of Hunter College of CUNY from 1980-87, and as chancellor of the University of Wisconsin from 1987-93. Her topic was "Health Care's Unfinished Agenda."

Secretary Shalala Speaks

Given the timing of the meeting (the California gubernatorial recall election on Tuesday and the opening games of baseball's divisional playoffs), President Shalala began by revealing two facts about her that do not appear on her resume. When President Bill Clinton appointed her as Secretary of HHS, one of her direct reports was Arnold Schwartzenegger, then Chairman of the President's Council on Physical Fitness. She had an opportunity to meet with him to review his work in that role, and found him to be a well organized, disciplined person who had accomplished much in his volunteer role. Impressed by his ability, she asked President Clinton to allow Schwartzenegger to continue in that role. The President responded, "But Donna, he's a Republican."

Undaunted by her first Presidential veto, Secretary Shalala next approached Mr. Schwartzenegger's uncle-in-law, ranking Democratic Senator Ted Kennedy, knowing that the Senator had a first-hand awareness of Arnold's abilities. Proving once again that family may be family, but politics is politics, Uncle/Senator Ted responded, "But Donna, he's a Republican."

President Shalala grew up in Cleveland, where she was an avid participant in sandlot softball. Her team was quite successful, and after winning a tournament, they were approached by a gentleman who advised them that, if they could learn to throw overhand and slide, they would be quite a success in Cleveland's Pigtail League. He volunteered to coach them and, to this day, George Steinbrenner contends that Donna Shalala is the best shortstop that he ever coached (Derek Jeter - please note the distinction).

(continued on page 16)

(continued from page 15)

Healthcare's Unfinished Agenda

As President of the University of Miami, Dr. Shalala's responsibilities include oversight of a medical school, and relations with Jackson Memorial Hospital, the 1,400 bed academic medical center that provides care to 80 percent of Dade County's indigent population. As such, she is immersed in a microcosm of healthcare in America today. She related her experience that very week in a meeting of the faculty Senate that debated issues including rising health insurance premiums (which affects their own pockets) as well as adequate funding for graduate medical education (which affects their career choices). She stated her opinion that there is no significant solution on the horizon and noted that, at the end of the day, the enemy is us. Americans always want the best, but don't always want to pay for it.

America's healthcare delivery system differs from the rest of the world, combining high tech with high choice. In other developed nations, choice is more limited. She believes that the health care system will always be "in some state of broken," noting that, in her opinion, the only path to a real solution is campaign finance reform.

President Shalala pointed out that it's no longer the aging of the population that's driving up health care costs, as was the case in the 1980s and 1990s, noting that Medicare beneficiaries do not have prescription drug benefits. Currently, health insurance premiums for family coverage average $9,000 per year. She related one startling fact revealed by recent research: evidence indicates that employees who retire early tend to get sicker than those who work until or beyond normal retirement age. She expects this development to have some impact on the Medicare reform debates that currently are raging.

Forecast 2004

President Shalala speculated that, if the economy comes back, there will be less discussion about health care costs in the upcoming Presidential election. To the general public, the two big issues are the economy and the war. However, medical error rates and patient safety issues are just beginning to appear on the political radar screen, and could become "sleeper issues" in the 2004 campaign. The general public believes that hospitals should be required to put systems in place to reduce medical errors, and that patients should go to "centers of excellence" for specialized care. Recent surveys show that the public believes that health care costs are rising for three key reasons: 1. drug costs; 2. malpractice awards; and 3. greed and waste in the healthcare delivery system.

She sees many parallels to the 1992 Presidential election, when health care costs was a front burner issue. However, only twelve percent of Americans currently view health care costs as the number one issue compared with more than half of Americans in 1992. Although the lay of the political landscape is similar to

when Bill Clinton ran for President in 1992, the key difference is public perception. We are in dire straits heading into the 2004 Presidential election: employers are increasingly concerned about health benefits costs adversely affecting their ability to compete in the global market place; senior citizens are clamoring for prescription drug coverage, and the general public want quality healthcare at an affordable cost. As a nation, we need to develop agreement on the standards of care.

President Shalala concluded that we will get this mess straightened out only if the large purchasers of care can reach consensus.

Leading Change in Uncertain Times

A four-time Emmy award winner, Featured Speaker Steve Adubato, Ph.D., coached attendees on the critical skills essential to effective change management. Dr. Adubato is well-known as an anchor for Channel 13/WNET, as well as for "Stand & Deliver," the dynamic, hands-on professional development and training program that he created to help today's professionals reach their potential as leaders. His Ph.D. in mass communication is from Rutgers, the State University of New Jersey. Dr. Adubato's research has focused on the role of the media in wartime and its impact on public opinion and public policy generated from the White House and the Pentagon, particularly relevant given the recent war in Iraq, and the continuing casualties being suffered by U.S. troops.

Dr. Adubato asked the audience for reasons why change efforts fail, and got a solid response. Reasons given by audience members included:

✓ Fear of the unknown - most employees are comfortable with the status quo, and aren't given enough information to understand "What's in it for me?"

✓ Fear of failure - often, a top down mandate sets goals that are unattainable;

✓ Lack of consistent follow-up - Executive management's priorities shift, and the message becomes mixed;

✓ Lack of feedback - employees often aren't given the opportunity to feed back their concerns about the effects of the change, nor to offer their expert advice on alternative approaches and options.

Following extensive discussion, audience involvement and an illuminating video, Dr. Adubato summarized with his 10 keys to leading change in uncertain times:

1. Communicate that there is an urgent need to change and that the status quo no longer is acceptable;
2. Tell people clearly the consequences of not changing;
3. Communicate the tangible benefits of the change - what's the payoff?
4. Don't sugar coat the pain and sacrifice involved in implementing the change;
5. Don't try to enforce compliance. It's a waste of time - people will outlive you;
6. Be open to feedback and to alternate approaches to implementing the change;
7. Celebrate and recognize even the smallest accomplishment;
8. Great leaders use opposition or resistance to change as an opportunity, not a threat or problem, and solicit opposing points of view in open meetings. Such open discussion gives opponents comfort that their views are being recognized, and frequently results in a better approach;
9. Have fun implementing needed change, even though it may be painful; and
10. FOLLOW THROUGH!

Following his inspiring presentation, Dr. Adubato stayed on to sign copies of his new book, "Speak from the Heart: Be Yourself and Get Results." I wholeheartedly recommend it to any of my colleagues who may feel shy or reluctant to speak out in public. While much of what Steve offers is "Applied Common Sense 101," it's done in a light and eminently readable style. To quote former New Jersey Senator and New York Knick Bill Bradley, "It took me ten years of public speaking to learn what 'Speak from the Heart' shares in a few hours of reading...A great resource and a fun read!" While Dr. Adubato quotes many luminaries including Tommy LaSorda on overcoming shyness and Joe Torre on remaining calm in the midst of a storm, NJHFMA members will be particularly interested in Ron Del Mauro's views on maintaining the personal touch in a large organization.

Top-Notch Technical Sessions

One recurring theme throughout the two-day Institute was performance benchmarking. The program included excellent presentations on benchmarking to improve revenue cycle performance by Allen DeKaye (DeKaye Consulting) and Donna McGregor (HealthQuest), "Overcoming the Dilemma of Profitless Growth" by Tom Kleman and Michelle Hartwell (H*Works, The

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Advisory Board Company) that addressed enhancing overall operating margin with case studies of implementing best practices in the revenue cycle, cost discipline and capacity management, and Phil Gaughan (Solucient LLC) sharing techniques for productivity benchmarking. Health care lobbyist Jeanne Scott provided a wealth of information on the alternative approaches to providing senior citizens with prescription drug coverage as part of a comprehensive legislative update.

Pam Federbush (Moody's Investor Services) opened Friday morning's "Creative Financing" panel with some eye-opening insights into Moody's medians for New Jersey hospitals for the past five years, including how the current medians compare with national medians. In a mix of good news with bad news, while New Jersey hospitals have reduced days in accounts receivable by 13.9 days from 67.2 days in 1998 to 53.3 days in 2002 (national median 57.8), the average payment period has increased 8.2 days from 59.4 days in 1998 to 67.6 days in 2002 (national median 59.9).

Following the morning coffee break, a panel of insurance experts provided insights into several unique risk management financing arrangement that might be helpful to hospitals attempting to cope with the medical malpractice issues. The final speaker, Wendy Leebov (Sustainable Solutions), author of "The Indispensable Healthcare Manager," shared her insights on how healthcare organizations can improve their human resource function to increase customer satisfaction, develop dynamic managers and teams, foster alignment with organizational goals and retain talented people.

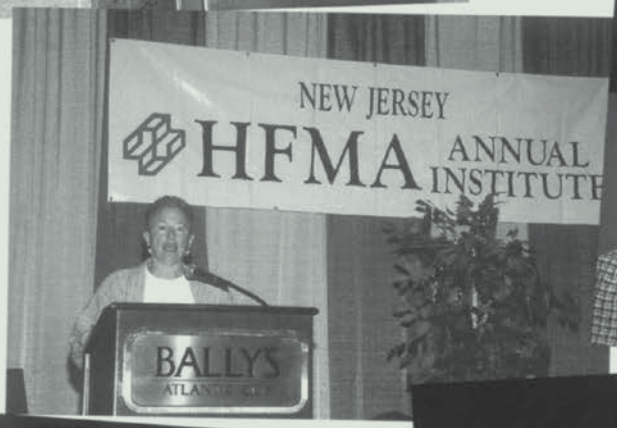
And the Winner Is...

The Institute concluded with a grand prize drawing for a Vacation Voucher sponsored by CBIZ KA Consulting Services. Following each speaker, attendees were allowed to deposit one ticket into a drum (maximum of 10 tickets), and the winner had to be present at the drawing to claim the prize. After several turns of the drum to scramble tickets, President-Elect Rick Parker (CBIZ KA) drew the winning ticket. Present for the drawing - and winner of the Vacation Voucher - was former Chapter President John Calandriello, FHFMA, CPA, Chief Financial Officer at Saint Peter's University Hospital. Twelve CPEs and a vacation to boot - that's a productive AND profitable Institute.

The 2004 NJHFMA Annual Institute already is scheduled for Atlantic City's newest location - the upscale Borgata - on October 13-14, 2004. Save the date!

John Dalton, FHFMA, is Vice President, Sales and Marketing for NCO Financial Systems, Inc. in Oceanport, NJ. A former Chapter President and National Board member, Mr. Dalton was HFMA's 2001 Morgan Award winner for lifetime achievement in healthcare financial management.

Some Familiar Faces...



...And Less Familiar Attire

CHAPTER CELEBRATES 50th BIRTHDAY WITH RECORD INSTITUTE

NJHFMA 50th Anniversary

by John J. Dalton, FHFMA

Photographs by Michael S. Friedberg, CHE

With a "Records are made to be broken" attitude and former Health and Human Services Secretary Tommy Thompson as keynote speaker, Annual Institute Committee Co-Chairs Olga Barone-Allen and Caitlin Zulla led off the New Jersey Chapter's 50th year with record-breaking attendance. A total of 355 registrants participated in "Baby Boomers: the Stress Test for Healthcare," held September 28-30 at Caesar's Hotel & Casino in Atlantic City. The prior attendance record of 350 registrants was set in 2003, and the 2005 Annual Institute marks the fourth consecutive year that the New Jersey Institute has attracted more than 300 registrants.

This year's Institute broke from tradition in several ways to provide attendees with better value and, on balance, the changes were well received. In addition to being held two weeks earlier than in prior years, registrants were offered Day Pass Registration good for Thursday's program at a discounted rate. Moreover, the Thursday afternoon program featured three separate educational tracks:

1. Revenue Cycle Management;
2. Budget and Reimbursement; and a
3. CFO Boot Camp.

The Wednesday evening networking social opened the Institute with a Western theme Casino evening with each participant receiving playing chips to risk at Black Jack, Roulette and Texas Holdem' Poker. The evening concluded with a Texas Holdem' tournament. Kudos to Social Committee Co-Chairs Jane Ann Sheehan and Karen Johnson for a successful event.

Tommy Thompson, Sharon Langraf and John Manzi,

John Manzi

The Vendor Fair provided four separate opportunities for attendees to obtain information on products and services offered by more than 30 vendors offering services ranging from auditing, accounting and consulting services through a host of approaches to squeezing more cash from the revenue cycle. Unchanged was the Thursday evening cocktail party. Everyone dressed up and the shrimp were outstanding.

Tommy Thompson

Dorothy DeLuca & Mike Friedberg

Thompson Tells All

After welcoming attendees and thanking both the Institute Committee and the Social Committee for their outstanding efforts, Chapter President John Manzi introduced the Institute's keynote speaker, former Secretary of Health and Human Services (HHS) Tommy Thompson. Currently a partner at the prestigious Washington law firm of Aiken Gump, Thompson served as HHS Secretary throughout President Bush's first term. His distinguished career in public service began when he was elected to Wisconsin's Assembly in 1966 and includes serving an unprecedented four terms as Governor of Wisconsin from 1987 to 2001. In 1996, Secretary Thompson enacted Wisconsin Works, or "W-2," the state's landmark welfare-to-work legislation which served as a national model for welfare reform. The monthly welfare case load declined dramatically, while the economic status of those taking part in W-2 improved. The average family on AFDC had been 30% below the federal poverty level (FPL). Conversely, families leaving W-2 were earning an average wage 30% above the FPL.

Class Shot

On the health care front, BadgerCare – Wisconsin's Medicaid/State Children's Health Insurance Program for uninsured families – had enrolled more than 77,000 individuals. In addition, Wisconsin's Pathways to Independence was the nation's first program to allow the disabled to enter the workforce without the fear of losing health benefits. The program provides ready access to a coordinated system of services and benefits. As governor, Thompson also created FamilyCare, designed to help elderly and disabled citizens, and allow them to receive care in their homes for as long as possible.

In his opening remarks, Secretary Thompson reminded attendees that HHS is the largest department in the federal government, with more than 67,000 employees with a fiscal year 2005 budget of $584 billion. To place that in perspective, Thompson noted that that amount exceeds the gross domestic product of all but five countries (U.S., Germany, Japan, England and Italy). In an ironic tone, Thompson noted that the HHS budget exceeds France's GDP. In another attempt at humor, Secretary Thompson quickly summarized the conflicting results of numerous health studies, concluding that "You should eat and drink whatever you want. It's speaking English that kills you."

Joe Samples, Karen Johnson, Jim Pender

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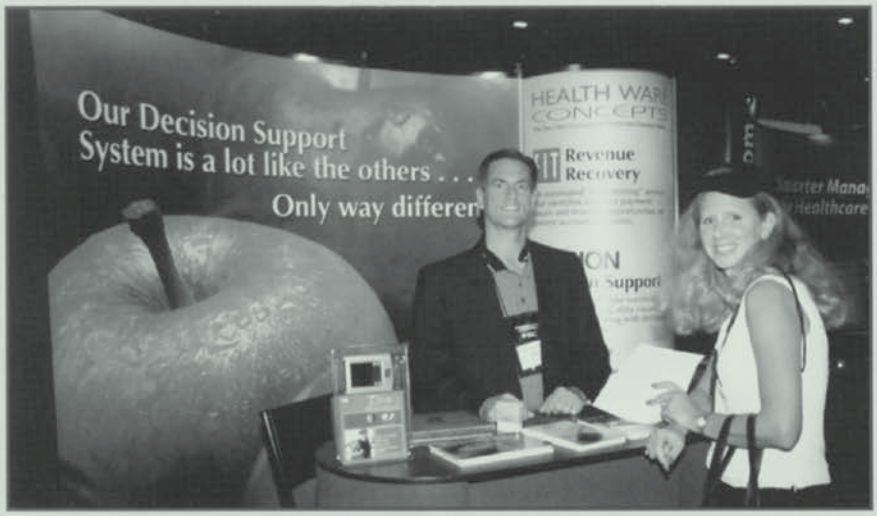

Health Ware Concepts booth

Secretary Thompson stated that his passion is to change healthcare, and that "America's healthcare system is the best in the world, and it's worth saving." He cited the year 2013, when Medicare goes into a deficit position, as the beginning of a crisis. Currently, healthcare spending of $1.8 trillion consumes 15.4% of GDP. He compared U.S. spending to Japan, where healthcare consumes only 7% of GDP. Part of the reason General Motors (GM) has difficulty competing with Japanese cars is that healthcare costs average $1,525 in each car GM produces compared with $350 in each Toyota.

By 2013, U.S. spending on healthcare will total $3.6 trillion, fully 29.5% of GDP. Worse still, current projections have Medicare going bankrupt in 2020. Secretary Thompson believes in consumer-driven health care and noted that "Moving to a single payor system would be a mistake."

Targeting Healthcare Spending

Secretary Thompson noted that 75% of healthcare spending is for treatment of chronic illnesses. He recommended starting with a stronger focus on lifestyle issues, citing a critical need for disease management and prevention. Tobacco related illnesses consume enormous resources, and the typical smoker's life expectancy is 14 years and seven months less than a non-smoker. At $135 billion, diabetes accounts for one twelfth of healthcare spending. Obesity is reaching epidemic proportions, especially among our youth.

Noting that the healthcare sector under spends on information technology (IT), Secretary Thompson recommended a mini Hill-Burton program to transfer health care technology. Citing the Institute of Medicine study that reported that roughly 94,000 deaths occur each year from preventable medical errors, he suggested that broader use of electronic medical records and use of technologies like ePrescribe could drop that number dramatically.

The Office of the Inspector General's fraud and abuse investigations yielded $1.8 billion last year. Secretary Thompson recommended dedicating those funds to improving access, affordability, efficiency and quality. He would put the country's 45 million uninsured into no frills insurance risk pools with a $75,000 catastrophic cap. He also proposed a radical restructuring of Medicaid, the federal-state program for the poor. Secretary Thompson would have the states pay 85% of acute care costs for Medicaid enrollees, with the federal government covering 85% of institutional care and long term care.

Secretary Thompson pointed with pride to the Medicare Modernization Act, stating unequivocally that "Part D is a good thing." Consistent with his focus on disease management and prevention, the Medicare program now covers an "induction physical" for new enrollees. In response to a question from a physician, Secretary Thompson agreed that medical liability insurance must be changed, noting that during his term as Governor, Wisconsin had implemented a $350,000 cap on damages.

Hospitalists Cut LOS

Brian Patrick, M.D., moderated a panel on "Hospitalists: Outcomes & Financial Impact," that provided illuminating insights into the growing use of hospitalists in inpatient care. Panelists included:

- Robert Lahita, M.D., Ph.D., Chairman of Medicine at Jersey City Medical Center;
- Aaron Gottesman, M.D., Director of Hospitalist Services at Staten Island University Hospital;
- David M. Schreck, M.D., M.S., FACP, FACEP, Chairman of Emergency and Hospital Medicine at the Summit Medical Group and Vice Chairman of the Department of Medicine at Overlook Hospital; and

- Jack Percelay, M.D., M.P.H, Director, Virtua Inpatient Pediatrics and Chair of the American Academy of Pediatrics Section on Hospital Medicine.

While each of the panelists provided his own insights into this emerging area of practice, some common themes emerged. All of the panelists were emphatic that hospitalists are not just doctors providing house coverage. Hospitalists manage care. While the models implemented vary, hospitalists usually are salaried physicians who work 12 hour shifts with seven days on followed by seven days off. Hospitalists do not do post-discharge follow-up – the patient returns to his/her primary care physician (PCP) for after care as needed. Since hospitalists work full time at the hospital, they are able to see assigned patients at least twice a day, and consult with the PCP as needed.

MDX booth

In most instances, hospitalists have recently completed their residency programs and are equipped with the most current medical knowledge, a real plus when dealing with acutely ill patients. Hospitalists are able to make effective use of Physician Assistants and Nurse Practitioners for data collection and collation when making judgments on specific cases. The typical hospitalist can handle 15 patient encounters per day.

The proof of their effectiveness was documented in Dr. Lahita's presentation. When the new Jersey City Medical Center opened its 367 beds in July 2004, it experienced a significant increase in both managed care and Medicare admissions. Prior to implementing its hospitalist program, length of stay averaged 6.8 days and denials were a significant issue that threatened the Medical Center's financial condition. The hospitalists are former residents with salaries averaging $100,000 per year. As a result of the hospitalist program, denials have been greatly reduced, and length of stay currently averages 4.6 days, a dramatic 2.2 day reduction in just over a year.

Parente Randolph booth

Where To Next?

Following a day and a half jam packed with useful information, the 29th Annual Institute concluded at 1:00 p.m. Friday with Chapter President John Manzi announcing that next year's Co-Chairs will be Mike Alwell and Michael Friedberg, and that the Institute will be held October 11-13, 2006 at the Borgata. The grand prize drawing for a $4,000 vacation voucher was won by long time Chapter member Peter Chuck, FHFMA, CPA, Director of Budget and Reimbursement at Trinitas Hospital. A productive two days for Peter – 11 CPEs and a jump start on his next vacation. And, for the New Jersey Chapter, a terrific start for its second 50 years.

About the author:

John J. Dalton, FHFMA, is Senior Advisor to Revenue Cycle practice at Besler Consulting in Princeton, NJ. A former Chapter President and National Board member, Mr. Dalton was HFMA's 2001 Morgan Award winner for lifetime achievement in healthcare financial management.

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Then and Now

Did you correctly guess the faces on our Institute brochure?

Brenda Emmons

Brian Sherin

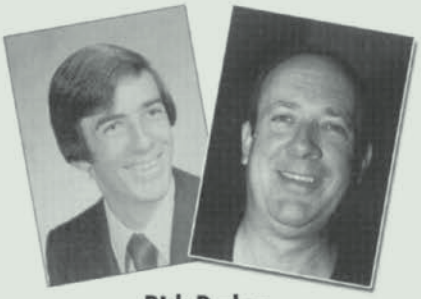
Fred Stodolak

Cheryl Cohen

John Manzi

Laura Hess

Pete Allan



Rick Parker

Marilyn Koczan

Liz Schaub-DeBlock

Stella Vissaggio

Phil Besler

Mary Taylor

NJHFMA 50th Anniversary

Save the date!

Annual NJ HFMA Golf Outing

Thursday, May 6, 2021, 1PM shotgun start

NEW LOCATION
Mercer Oaks
West Windsor Township, NJ

Prizes and raffles!

Sponsorship opportunities will be available.
More Information Coming Soon!