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national excellence award winner

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- Managing Interpersonal Conflict in these DEI-Focused Times

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DEADLINE FOR SUBMISSION OF MATERIAL

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

IDENTIFICATION STATEMENT

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OBJECTIVE

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

EDITORIAL POLICY

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

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

Brian Herdman

The cold winter of COVID-19 continues to thaw in New Jersey and across the country. The business of healthcare continues, with providers facing the reality of operating without the flexibilities of the PHE and its various waivers.

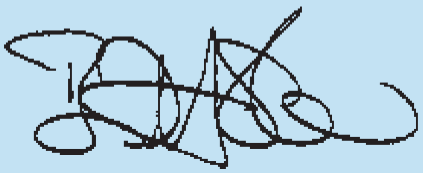
The New Jersey HFMA chapter has been busy helping our members cope with these changes while simultaneously managing the added strain of new cost pressures that are widespread in the current healthcare operating environment. If you are not a member of a committee in your lane of healthcare – check out our list of committees on page 25 so you don't miss on big ideas. Your brilliant peers in the industry are eager to share their wisdom in removing barriers to proper reimbursement.

The chapter hit the ground running in 2023 – our joint Patient Financial Services / Patient Access Services committee met in person for a full day at the end of January, and our FACT (Finance, Accounting, Capital, and Taxes) committee staged a virtual session with three hours of content. Don't miss your chance to network and build your healthcare financial management expertise at these upcoming events:

- April 4, 2023: CARE Forum (Compliance, Audit, Risk, Ethics) – In person full day education
    - Preparing for the end of the PHE and return of HIPAA enforcement.
    - Hear from Tom Scott, President/CEO of CentraState Healthcare System on their cyber incident, then listen to the follow-up panel of cyber risk experts on reducing your exposure.
    - Join the conversations on privacy and compliance management; and workforce issues as we begin the spring recruiting season for college graduates.
    - Grow your expertise in other sessions on Sepsis Denials and Risk Adjustment methodologies.
- May 11, 2023: Golf Outing at Mercer Oaks, West Windsor, NJ
- May 17, 2023: Women's Leadership and Professional Development Session: How to be a better you
    - Special guest speaker, Caitlin Zulla, CEO Optum Health East.
    - Other panels on growing your business savvy and bridging work/life balance.

Visit our chapter website, https://hfmanj.org/ for more information and links to register.

It will be a busy spring for the Chapter, don't miss out on your opportunity to build your personal and professional development. I'll see you out and about!



From The Editor . . .

Jill Squiers

As we leave Winter behind and close in on Spring, we're preparing for a busy season for the New Jersey Chapter of HFMA. This edition of the Garden State *FOCUS* starts with a retrospective on the 46th Annual Institute, during which our longtime Master of Ceremonies John Dalton handed the baton to Mike McKeever, who will continue as our emcee in future years. We thank John for his years of service to the Chapter and look forward to seeing him again in a more relaxed role as guest at this year's Institute on September 27-29!

Included in this *FOCUS* are articles addressing the important topic of Medicare finance through an examination of GME payments and 340B programs as well as a timely piece from an assistant commissioner in New Jersey's Department of Human Services discussing the imminent process of Medicaid redeterminations, which begin April 1. A review of False Claim Act cases and the application of the "but for" causation standard kicks off our contributed articles. We also include a constructive examination of how to overcome stragglers who do not want to embrace an employers' Diversity, Equity and Inclusion policies.

This edition also introduces a new feature, the Committee Corner, within which we highlight a Chapter forum or committee through an interview with its chairs. Our inaugural piece recognizes the valuable work performed by our Membership Services and Networking Committee, responsible for onboarding new members and creating fun networking events for you!

Please visit our Chapter website at https://hfmanj.org/ for information on our upcoming events, including our Golf Classic and Women's Leadership Conference!

Jill A. Squiers

Attendees "Ignite the Spark" at 46th Annual Institute

John Dalton

by John J. Dalton, FHFMA

The New Jersey and Metropolitan Philadelphia HFMA Chapters hosted a successful educational institute at Atlantic City's Borgata Hotel and Resort from October 26-28. With more than 400 registrants – unmasked for the first time since 2019 – the energy and enthusiasm was tangible, igniting the spark for a successful year for both Chapters.

The Institute opened Wednesday with a Welcoming Lunch, after which Chapter President Brian Herdman welcomed attendees, thanked the vendors and sponsors for their support and introduced John Dalton, serving once again as Master of Ceremonies. Dalton is a former Chapter President and recipient of HFMA's Lifetime Achievement Award.

Dalton briefed attendees on several housekeeping items including use of the Crowd Compass app for selecting sessions to attend and submitting evaluations and encouraged them to open their wallets for the Community Food Bank of New Jersey at the charity event Wednesday evening in the Vendor Hall. Next, he introduced Mike McLafferty, CEO and founder of MJM Advisory and Educational Services for the current events and regulatory update. McLafferty chairs the Chapter's Physician Practice Forum and hosts "The Healthcare Maze" podcast.

McLafferty's presentation focused first on aspects of the Inflation Reduction Act and finalization of the independent dispute resolution process in the No Surprises Act. Other updates included the Centers for Medicare & Medicaid Services final rule for FY2023 inpatient payment and the proposed rule for outpatient payment, cybersecurity concerns, private equity's involvement in specialty care and Medicare Advantage plans.

Wednesday night's Charity Event benefited the Community Food Bank of New Jersey, the state's largest anti-hunger, anti-poverty organization. The event raised $5,000 to support their mission, including a contribution of $1,437.50 to reach our stated goal from D. Lawrence Planners, L.L.C., without whom the Annual Institute would not be the winning event that it we all enjoy each year. Adding to the fun this year's Charity Event had a Halloween theme, complete with a booth decorating contest for the sponsors. Congratulations to Affiliated Healthcare Management Group, LLC, for having the scariest booth! But when you come down to it, hasn't healthcare financial management always been a little scary?

Thursday opened with immediate past president Jill Squiers presenting Chapter Awards to members who had achieved Follmer Bronze, Reeves Silver and Muncie Gold Awards (see Fall 2022 issue, page 29 for a complete listing), then concluded by presenting the Chapter President's Award to John Dalton for his outstanding service to the Chapter, including more than 20 years as Master of Ceremonies for the Annual Institute. Dalton thanked the Chapter for the honor and welcomed attendees, especially those from the Metropolitan Philadelphia Chapter whose Phillies were in the World Series, with the Eagles off to a great start. He then announced that he will be retiring from his role as emcee and was sharing duties with his replacement, another former chapter president, Mike McKeever, who is currently serving as Regional Executive.

Dalton then introduced Katrina Campbell, Chief Ethics and Compliance Officer at Relief International, to discuss "Managing Interpersonal Conflict in these DEI-Focused Times." A Harvard-educated attorney who has worked with clients in more than 30 countries and 40 states, Campbell used case studies to assist attendees on the Diversity, Equity and Inclusion journey, including:

- How to address situations in which you are committed to the DEI journey but not everyone agrees on this direction, and
- What to do when colleagues engage in behavior that conflicts with, or even threatens, your vision of a harmonious work environment.

Campbell concluded with several suggestions on how to effectively manage interpersonal conflict.

Next up, Roselyn Feinsod and Julie Dumser from Ernst & Young discussed "Four Ways for Health Systems to Get Ahead in the Race for Talent." In August 2022, 4.2 million people quit their jobs as the Great Resignation shows no sign of slowing down, and healthcare is no exception. Clinician burnout

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during the COVID-19 pandemic has exacerbated staffing shortages. Their recommendations included the following:

1. Leverage leading technologies to measure employee sentiments and performance on an ongoing basis;
2. Reimagine operating models with employee experience and satisfaction at the center;
3. Develop career framework, job families and other talent management solutions to mitigate burnout; and
4. Create a matrix of rewards trade-offs that are consistent with budgetary realities and conduct surveys to gauge preferences and impact.

Keynote Address

Dr. Ronald Hirsch is VicePresident of R1 RCM's Regulations and Regulations Group and a frequent speaker at the Annual Institute. Entitled "No Data is Better than Bad Data – Every Measure You Trusted is Wrong," Dr. Hirsch's address skillfully dissected the faults and flaws in commonly used utilization review measures widely used as key performance measures (KPIs). He included case mix index, length of stay (LOS), readmission rate, observation rate, observation hours, denial rate and discharged, not final billed (DNFB).

In theory, a shorter LOS should lead to lower costs. However, risk-averse physicians often are reluctant to discharge until comfortable that the patient is ready to go home. Dr. Hirsch noted that readmissions often are unrelated to the care provided. He also suggested targeted analysis of DNFB elements to identify outliers (e.g., physician queries outstanding, discharge summary not done).

Hospitals emphasize getting high patient satisfaction scores. However, Dr. Hirsch pointed out an unintended consequence: the opioid crisis in part was attributable to attempts to improve patient satisfaction with pain management. Concluding the address, Dr. Hirsch suggested that hospitals focus on measuring avoidable days and avoidable delays since such data can lead to operational improvements and lower costs.

Thursday evening's President's Reception was held in the Borgata's Event Center from 6:00-8:00 pm with a full house. At the Late-Night Dance Party in the Premier Nightclub, an enthusiastic crowd filled the dance floor until its 1:00 am closing.

Friday's Finale

Despite a late night, there was a full house Friday morning to hear Reggie Hodges discuss "When Passion Meets Purpose." Initially drafted in 2005, his eight-year National Football League career was marked by repeated cuts until his final four years with the Cleveland Browns. Holder of the NFL record for the longest run by a punter (68 yards), his efforts off the field were just as important. He served as a mentor and spiritual leader in the locker room, helping teammates to develop their spiritual, emotional and mental health skills along the way.

His key message to attendees: "Your passion will lead to your purpose."

Friday's second session featured a panel discussion on "Winning the War for Talent in Healthcare" moderated by Mary Torretta of Grant Thornton. Panelists included Nick Barcellona, Executive Vice President and Chief Financial Officer at Temple University Health System, Jessica Shure, Vice President of Performance Improvement at Lehigh Valley Health Network and Eric Gonzaga, Grant Thornton's national practice leader for Human Capital Services.

The panelists first covered the state of work for healthcare in America. The aging healthcare workforce is facing increasing demand for healthcare services with 22.0 percent of the population over age 65 compared with 12.5 percent in 2000. Turnover rates for registered nurses have increased and replacements are hard to find. The current vacancy rate is 17 percent and it takes an average of three months to recruit an experienced registered nurse.

The panelists recommend thinking like a marketer – reducing turnover by 10 points for a 1,000-person workforce could save $4 million annually. They also recommended employers use workforce analytics to assess workforce availability in your geographic area and understand how competitors are positioning themselves in the war for talent. Lastly, the panelists suggest companies conduct onboarding and offboarding surveys to understand what attracts employees and why they are leaving.

The panel concluded with two case studies of hospital systems that optimized employee benefits and competed successfully for skilled talent. In the first case study, a shift of money from funding a retirement package to healthcare benefits resulted in delivering more value to employees while saving $1,250 per employee per year. In the second case study, the health system was able to reduce turnover of critical talent with targeted changes in the benefits package that competitors that were difficult for competitors to replicate.

CFOs Panel

The 46th Annual Institute concluded David Gregory, Principal and Healthcare Industry Leader at Baker Tilly, leading a panel of chief financial officers through a discussion on "Forging a Path to Financial Sustainability for Hospitals and Health Systems." Panelists included Garrick Stoldt of Sant Peter's Healthcare System, Herb White of Hunterdon Healthcare and Gail Kosyla, who is moving to Connecticut to join Yale-New Haven Health as CFO.

Nine months into a challenging year, margins have fluctuated widely, and many organizations are operating with negative margins and well below pre-pandemic levels. New market

entrants present strategic challenges with disruptors chipping away at profitable outpatient services and Epic, Oracle and Microsoft are dominating the hospital scene, but their value has yet to be determined. Gregory asked the panelists to describe the top challenges facing their organizations in three categories (labor, supply chain and payers), beginning with labor.

Gail Kosyla noted that labor costs as a percentage of total expenses had increased dramatically during the pandemic, principally due to the increased use of travel and agency nurses. Remedies include recruiting nurses offshore and changing conditions to make the workplace more attractive. Garrick Stoldt agreed, noting that the nursing shortage was much worse than what hospitals experienced in the 1980s. He suggested offering staff nurses the less desirable night and weekend shifts at pay rates equivalent to what an agency would pay. Gregory noted that the Mayo Clinic projects that 35-40 percent of its admissions will, in part, have hospital at home care.

Turning to the supply chain, Stoldt noted that just-in-time ordering and inventory practices failed during the pandemic and that group purchasing organizations (GPOs) are not necessarily working in their customer's best interest. He suggested moving to "just-in-case," adding more storage capacity for certain critical items. Herb White agreed that GPOs are a necessary evil, and that every order should be a negotiation. Offering a one-year warranty – why not two? The panelists agreed that China is not a reliable source for critical items even if its prices are lower.

When it comes to payers, White suggests investing in revenue integrity and denials management. He cultivates positive relationships with major payers, holding quarterly meetings to discuss and resolve issues. Stoldt observed that payers have both ramped up denials and delayed appeals adjudication, creating significant payment backlogs. With interest rates increasing, payers are doing all in their power to hold onto cash.

Gregory then turned the topic to some of the more global issues. How are systems dealing with disruptive market entrants? Will there be more direct contracting by self-insured employers? Kosyla stated that hospitals can no longer be everything to everybody and must concentrate on the services that only they are uniquely equipped to provide. Low acuity services are leaving hospitals – partner when possible.

Stoldt noted that several states are pushing reference pricing and looking to move volume to the lowest price provider. New Jersey has the highest number of ambulatory surgery centers per capita in the country and typically they only accept insured patients, leaving the uninsured to hospitals to care for. Little time was left to discuss direct contracting although White noted that it takes scale (5-10,000 covered lives) to consider it.

About the Author

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


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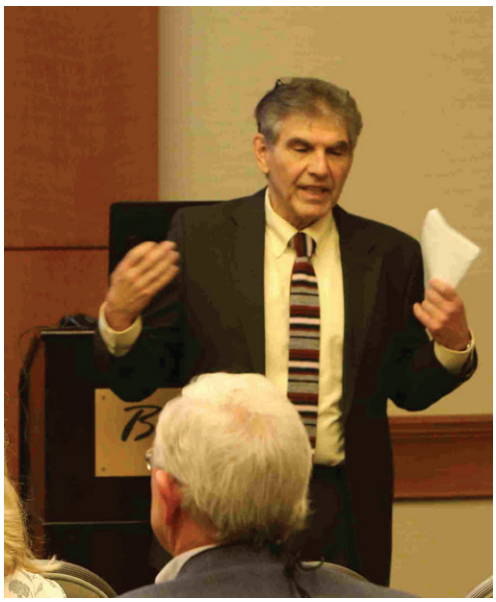

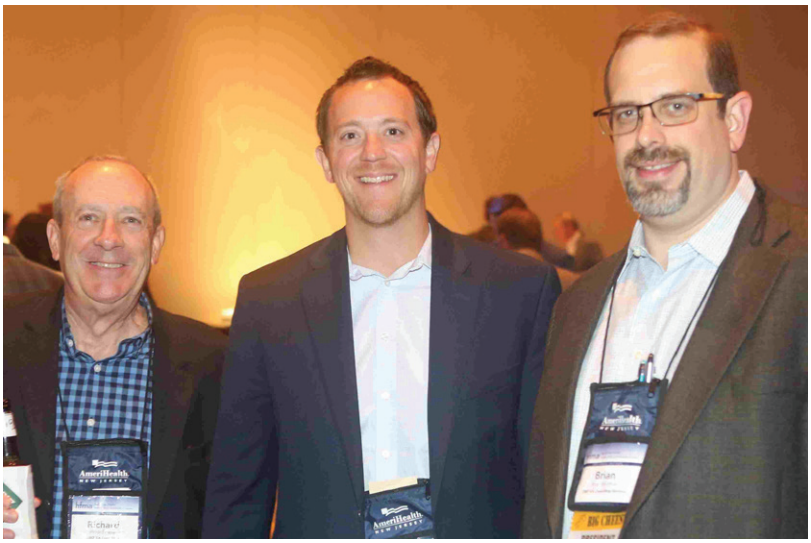

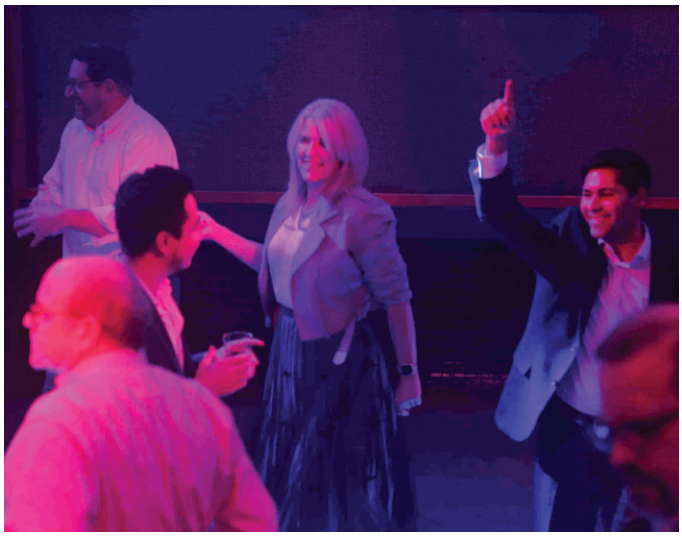

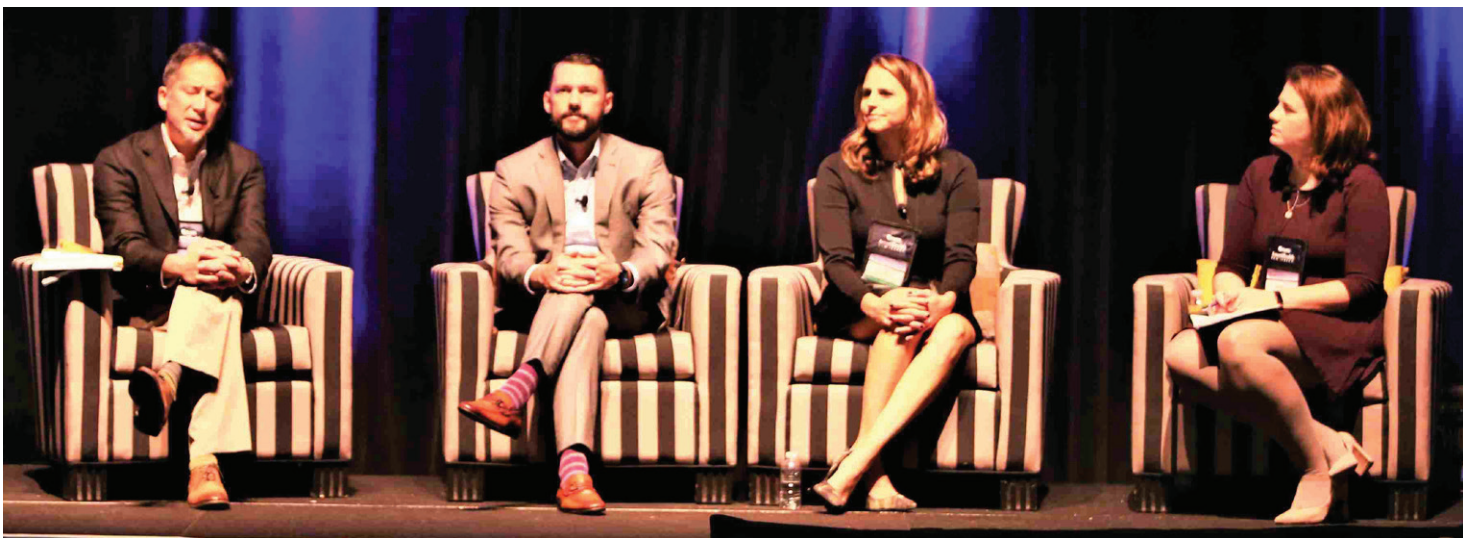


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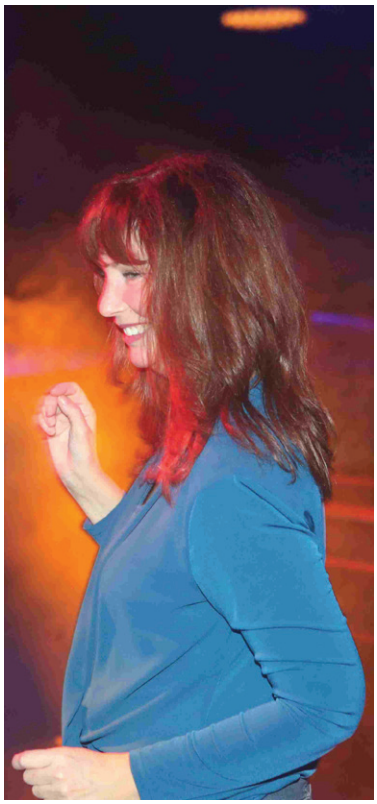

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Eighth Circuit Imposes New "But-For" Causation Standard for False Claims Act Cases Premised on Anti-Kickback Violations, Causes Circuit Court Split

Christopher D. Adams

Robert B. Hille

by Christopher D. Adams and Robert B. Hille

The federal False Claims Act ("FCA") imposes civil liability on anyone who presents or conspires to "present[ ] ... a false or fraudulent claim" to the government.[1] FCA liability is usually related to the provision of goods or services that are included in the claim. The federal antikickback statute ("AKS"), which was amended in 2010, states that submitting a claim to the government that "includes items or services *resulting from* a[n] [anti-kickback] violation" makes a claim "false or fraudulent" under the FCA.[2] Plainly stated, the government's broad interpretation has been that any claim submitted that violates the AKS is tantamount to committing a FCA violation.

Recently, the United States Court of Appeals for the Eighth Circuit departed from other Circuit Court's view of FCA liability based on an AKS violation[3] and imposed a different causation standard for FCA cases premised on AKS violations. In *United States ex rel. Cairns v. D.S. Med., LLC*,[4] a neurosurgeon used certain spinal implants to treat degenerative-disc disease and other spinal disorders. The implants were made by a number of manufacturers, but the neurosurgeon chose to use only implants that were distributed by a company owned by his fiancée, resulting in millions of dollars in commissions to his fiancée's company. The neurosurgeon was offered to purchase stock in the manufacturer and once he did, he ordered more implants.

The *Cairns* Court interpreted the plain language of the statutory words, "resulting from," in the 2010 AKS amendment, reversed the neurosurgeon's conviction, and remanded the case for a new trial. Agreeing with the interpretation by the United States Supreme Court in *Burrage v. United States*,[5] of similar statutory language, the Eighth Circuit found that the phrase, "results from," essentially establishes "a requirement of actual causality." Therefore, when the government seeks to establish falsity or fraud under the FCA premised on an AKS violation, the government must demonstrate that "***but-for*** the illegal kickbacks," the neurosurgeon would not have included particular "items or services" in his claims to the government.

While the *Cairns* decision is the first case that has established a "but-for" causational standard, the decision creates a split with our Third Circuit which has held that although the AKS's "resulting from" language re-quires some nexus between the reimbursement claims submitted and the kickback scheme, it ***does not*** require the government to show but-for causation. How the two Circuits have reached different conclusions is explained in *Cairns*. The Third Circuit looked to legislative history while the Eighth Circuit relied upon the plain meaning of the statutory language to interpret the statute.

Whether other District or Circuit Courts will adopt the *Cairns* "but-for" standard for FCA liability based on an AKS violation remains to be seen. However, while not controlling on other District and Circuit Courts, savvy defense counsel will no doubt be advancing this "but-for" causality standard in other courts across the United States, forcing these courts to side with the reasoning of either the Eighth or Third Circuits. Indeed, the split in the circuit courts is real and could very well prompt the United States Supreme Court to hear an appeal to definitively resolve the discrepancy.

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Special thanks to Rachel A. Frost for her assistance in writing this article.

Endnotes

[1]31 *U.S.C.* §3729(a)(1)(A), (C).
[2]42 *U.S.C.* §1320a-7b(g).
[3]*See United States ex rel. Greenfield v. Medco Health Solutions, Inc.*, 880 *F.*3d 89 (3d Cir. 2018).
[4]No. 20-2445, 2022 *WL* 2930946 (8th Cir. July 26, 2022).
[5]571 *U.S.* 204 (2014).

•Focus on...New Jobs in New Jersey•

JOB BANK SUMMARY LISTING

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

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The Relief of Some Financial Burden: CMS to Pay Back 340B Hospitals in 2023

Fatimah Muhammad

by Fatimah Muhammad, MPH & Marissa Kass

Marissa Kass

340B hospitals have been under extreme financial duress due to the impacts of the COVID-19 pandemic and the ultimate burden of providing care for vulnerable, low-income populations. Approximately 77 percent of all Medicaid hospital services were provided by 340B hospitals in 2020, and 67 percent of all care was uninsured and unreimbursed for a total of $41.6 billion of care[1]. Without 340B hospitals absorbing these costs of service, these patients might not have another opportunity to seek the medical care that they need. Patients receive fundamental access to treatment and medications through programs such as 340B in an effort to create a more equitable healthcare system. As these hospitals are a majority provider for Medicare and Medicaid services, the Centers for Medicare and Medicaid Services (CMS) is required to provide reimbursements to all 340B hospitals. Egregious financial cuts have been made by CMS regarding these reimbursement rates, but that will all change starting in the new year. After a court ruling regarding the new Outpatient Prospective Payment System (OPPS), CMS will begin to pay back these 340B hospitals starting in the new revenue cycle of 2023.

The 2018 CMS OPPS ruling detailed a nearly 30 percent cutback for the CMS reimbursement rate, resulting in an estimated $1.6 billion net savings for the federal government[2]. 340B hospitals faced a consequential financial burden due to the high volume of low-income patients served. In 2020, Disproportionate Share Hospitals saw a 74 percent decrease in operational profit margin between fiscal years 2019 and 2020, due to the many issues aforementioned and the large amount of unreimbursed care[3]. The accumulated loss of revenue resulted in many hospitals facing the fear of closures and the inability to meet patient needs in vulnerable communities. Due to over 3,500 hospitals affected by these cuts, advocacy groups such as the American Hospital Association and 340B Health fought these issues on a legal level[4]. The initial court case in 2020 was upheld and these steep CMS payment reductions continued, while the fight for reimbursement brought the case to the attention of the Supreme Court[2]. The case *American Hospital Association vs. Becerra* reversed these rulings in a unanimous decision in June 2022, stating that the cuts were unlawful without properly surveying the hospitals for current average acquisition costs of medications[4]. While the increase was not as significant as hoped for, hospital advocacy groups are still working to gain full reimbursement for the accumulated losses between 2018-2021[5] to combat the continuous rise of drug, labor and supply chain shortages currently plaguing the industry.

Starting January 1, 2023, the CMS payments will consist of the average sales price plus 6 percent, which will help to neutralize losses from the previous reimbursement rate of average sales price minus 22.5 percent[2]. The 2023 OPPS rate is the same compensation rate that it was back in 2018 prior to the decision by CMS to diminish the reimbursement amount. The CMS ruling will also propose the inclusion of a new Medicare provider type Rural Emergency Hospitals (REHs)[5]. REHs will help to expand provider access for rural communities by addressing the current financial landscape and geographic challenges in an effort to bridge the gaps due to the closures of rural critical access hospitals over the past few years[5]. The last modification identifies the exemption of rural sole community hospitals (SCH) for Physician Fee Schedule (PFS) payment rates that CMS currently provides, and offer full OPPS reimbursement rates for off-site, provider specified department clinic

continued from page 16

visits[4]. The PFS reimbursement is equivalent to approximately 40 percent of the OPPS rate, so this will provide more financial relief in rural SCHs[4]. These CMS OPPS ruling updates are major feats for improving access to quality patient care, in both 340B and non-340B settings.

So where is the 340B program going from here? Throughout its 30 years of implementation, 340B has faced criticism and backlash by the pharmaceutical industry regarding losses that these manufacturers face due to the discounts provided for the underserved. Due to the deficit from these CMS financial cuts, the 340B program has been facing an even greater hardship across the nation. These new OPPS regulations will allow for the program to regain some financial losses, in addition to optimizing outpatient dispensation captures. In the coming years, the program can regain their reputation as an essential service to low-income populations and provide essential benefits to the hospitals and surrounding communities. 340B will continue to gain national attention, and hopefully be implemented in more hospitals throughout the country as a result. The current questions at hand are: how long will it take for 340B entities to recoup losses? Will these entities be able to play catchup as result of their losses, and what can be put in place to ensure 340B programs and the populations that 340B entities serve are not subjected to unjust cuts and setbacks? We must not forget for over 25 years, the 340B program has played a critical role in helping hospitals expand access to care for vulnerable patients and communities, with drug discounts at no cost to the government. The 340B programs across the US have proven its strength, resilience, loyalty to serving its patients, populations, and surrounding communities and will continue to fight unjustified cuts and continue preserve access for patients.

About the authors

Fatimah has extensive experience in pharmacy, public health, and professional research while possessing an eclectic blend of interpersonal skills. She serves as the 340B Pharmaceutical Services Director at Saint Peter's University Hospital where she presides over all projects related to 340B. Her current endeavors focus on Health Disparities, Health Equity, Patient-Reported Outcomes, Community Health Promotion, and Disease Prevention and Health Services Research. She can be reached at fmuhammad@saintpetersuh.com.

Marissa Kass is an MPH candidate in Urban Public Health at Rutgers University's School of Public Health in Piscataway, New Jersey. She received her B.S. in public health from Rutgers University in 2021. She has served as an intern for the 340B Pharmaceutical Services Program at Saint Peter's University Hospital, which she describes the most fruitful internship a student could experience. This opportunity had allowed her to appreciate her journey as a future healthcare leader of tomorrow. Upon the completion of her internship, she was extended the opportunity to join the department as a 340B program analyst. Marissa is a member of HFMA, and possesses special interests in increasing healthcare access, maternal child health outcomes, health promotion and advocacy with hopes to educate and expand healthcare access for all.

FOOTNOTES

[1]*340B Health.* 340B DSH HOSPITALS PROVIDE 77% OF MEDICAID HOSPITAL CARE, NEW STUDY FINDS. (2022, September 26). Retrieved December 2, 2022, from https://www.340bhealth.org/newsroom/340b-dsh-hospitals-provide-77-of-medicaid-hospital-care-new-study-finds/

[2]*LaPointe, J. (2022, October 13). CMS will apply higher 340B Hospital reimbursement rate after court ruling. RevCycleIntelligence.* Retrieved December 2, 2022, from https://revcycleintelligence.com/news/hhs-must-restore-full-payment-to-340b-hospitals-now-judge-says

[3]*340B Health.* 340B HOSPITAL OPERATING MARGINS DROPPED SHARPLY IN FY 2020. (2022, July 20). Retrieved December 2, 2022, from https://www.340bhealth.org/newsroom/340b-hospital-operating-margins-dropped-sharply-in-fy-2020/

[4]*Fact sheet CY 2023 Medicare Hospital outpatient prospective payment system and Ambulatory Surgical Center Payment System Final Rule with comment period (CMS 1772-FC).* CMS. (2022, November 1). Retrieved December 3, 2022, from https://www.cms.gov/newsroom/fact-sheets/cy-2023-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-2

[5]*In OPPS final rule, CMS boosts payment rates by 3.8%; will pay ASP plus 6% for 340B Drugs: AHA News.* American Hospital Association | AHA News. (2022, November 1). Retrieved December 3, 2022, from https://www.aha.org/news/headline/2022-11-02-opps-final-rule-cms-boosts-payment-rates-38-will-pay-asp-plus-6-340b-drugs

NJ HFMA

Women's Leadership Event

How to Be a Better You!

Save the Date: May 17th, 2023

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Double Tree by Hilton Hotel Tinton Falls - Eatontown
700 Hope Road, Tinton Falls, NJ 07726

Featuring Keynote Speaker Caitlin Zulla, CEO, SCA Health

Managing Interpersonal Conflict in these DEI*-Focused Times
*DEI = Diversity, Equity and Inclusion

Katrina Campbell

by Katrina Campbell

Katrina Campbell is the Chief Ethics and Compliance Officer for Relief International, a humanitarian aid organization. She also teaches Business Ethics at Rutgers Business School. The views presented are her own and not necessarily the views of her employers.

This article discusses:

- How you can address situations in which you are committed to the DEI journey but not everyone agrees on this direction
- What to do when colleagues engage in behavior that conflicts with, or even threatens, your vision of a harmonious working environment

After George Floyd's murder by a police officer in May 2020, and perhaps even before that, many organizations launched, restarted and tried to re-energize their diversity programs. Many of these were re-titled DEI programs in response to advice from diversity experts that organizations must also be equitable and inclusive; some have gone further to emphasize "belonging" (thus – DEIB).

These organizations have proactively hired diversity chiefs and diversity consultants. They developed training, engaged senior leaders in DEI task forces and asked managers to learn how to have difficult conversations about race and gender.

Check LinkedIn during the months that are designated to celebrate black people, women, LatinX people, indigenous groups and others, and you will witness the public relations aspect of these efforts: statements of commitment to DEI from these organizations' CEOs, chief diversity officers, and other executives.

I believe this commitment (and the expressions thereof) is necessary, and is more honest than ever. Cynics among us worry aloud about whether this new DEI movement reflects real intention and action, or instead is just an attempt to appease the activists. But a few statistics reflect at least some progress. The Fortune 500 in 2022 has 44 women CEOs.[1] This is only 8.8 percent of that group, but it is a record high. It has just 6 black CEOs[2] (a whopping 1.2 percent) but is the highest number for a single year. The pipeline for other diverse senior leaders is harder to quantify, but Fortune recently reported that 15 percent of Fortune 500 chief financial officers are women.[3] Other industries also reflect increasingly diverse leadership.

There is work to do, of course. Thus, we press onward.

Meanwhile, there may be another contingent of stakeholders who are not so committed. As Denise Hamilton, founder of WatchHerWork said in October 2022, the backlash to DEI efforts is in full swing. She said she often fields questions about how to handle employees, especially white men, who only see the costs of diversity programs but don't see themselves included in the efforts.[4] Many people may feel like they are even being excluded so that marginalized groups can be included, as if there is a zero-sum game being played.

Some employees may think diversity is generally fine, but believe that the organization inappropriately prioritizes specific groups or categories. *Why racial prejudice? Ageism is much worse!* Or, *Women are already half of our workforce; why do they need preferential treatment?*

Some of your team members may grumble quietly about *this unnecessary diversity stuff.* Others may openly object, to colleagues, subordinates, managers or even externally. This is normal, even if you find it unacceptable. Substantive DEI programs disrupt old patterns and behaviors. Emotional backlash is a common response to change.

That backlash may manifest as misconduct, or other conflict in the workplace. When this happens, you have to decide how to manage it effectively. Properly addressing conflict is one of the best ways to positively impact employees, their pro-

ductivity, and the culture of the workplace. This is especially so when that conflict occurs in the context of your DEI program and efforts.

In deciding how to respond first consider the nature of the conflict. Is there an allegation of misconduct by an employee or other stakeholder? How do you know? For example, an employee's statement in a DEI training that *we already do too much for those* people may not qualify as misconduct under your policies (even if it is offensive to many); on the other hand, that employee's posting on internal chats where she complains about hiring immigrants may qualify.

Of course, you should investigate any credible allegation of misconduct, including discrimination or harassment. You should take prompt and clear action upon substantiating any such allegations (even when the stars are at fault). The same can be said for other allegations of significant policy violations.

But what about where there is no clear policy violation, or when the alleged violation involved a person merely voicing their fears and concerns about the impact of the DEI approach on their career (or, "what about me-ism")? This still calls for a response, if you care about the organization's culture. Each employee can impact your culture, and how you respond to their concerns will affect your culture.

This leads to a question, however. How do you deal with those who oppose your DEI initiatives? Can we just get rid of them, or push them aside?

DEI presumes not only diversity, equity and inclusion; it also means respect for all people as human beings. Surely this must mean that we emphasize equity for and inclusion (and belonging) of those who have been historically and are currently marginalized – racial and ethnic minorities, women, and disabled people, among others. Thus, #metoo and #blm and #stopasianhate, as well as the celebratory shout-outs for diverse senior leaders, are important.

But in addition, perhaps DEI champions can challenge ourselves to make room for the doubters and the "what about me-ers."

If we are unwilling to do so, then what? Are we ready to clean house? Is it even legally possible, or ethically appropriate?

Legal considerations may permit or restrict what you can do to those who oppose your DEI efforts. For example, the doctrine of at-will employment (particular to United States private sector employment) may allow you to discipline and terminate the employment of people for any reason *except* an illegal one. This can mean that employees who object to your DEI program may lawfully be fired or removed from their positions (in many cases).

On the other hand, government employees are generally not subject to at-will employment. They also have limited First Amendment rights in the workplace. Thus, unless you can justify their termination or change in role as being in response to a violation of some specific policy or law, you may be stuck with them (in most cases).

Beyond the law, however, you might consider your own organization's history. What expectations have previously been set for employee behavior and attitudes towards diversity and speaking up in the organization? Has the tone at the top always been about respect for diversity? If your culture has long supported diversity, those who object to diversity as an important value may find it difficult to remain at your organization because they won't fit in to your culture. That's a good thing.

But let's be honest. For many organizations, even the committed ones, this whole DEI thing is pretty new for many organizations and their employees. If so, can you realistically expect everyone to immediately pivot toward diversity? In other words, must everyone be "DEI perfect" from the very start even though the organization was not?

In my view, emphasizing diversity should not be a difficult choice. It is the ethically appropriate thing to do. Further, employers who continue to maintain cultures that exclude and marginalize diverse people (employees, suppliers, and other stakeholders) will soon find themselves excluded and marginalized. More than half of college graduates are women. Minority groups are no longer minorities in many places. Exclude us at your peril.

The tough choice is not about embracing DEI, but instead about how to manage those who are not so far along the DEI journey as your DEI champions are. Here, I offer a few recommendations:

- Require that new leaders be committed to leading the DEI effort. Walking the talk is real. And leaders know that sometimes they have to *fake it till you make it*. Those who cannot lead in this way should not be leaders. Their exit, or their demotion, is a good thing.
- Don't remove employees and other stakeholders simply because they voice concerns about DEI. Practically speaking, most organizations cannot afford to lose so many employees (because there may be a lot of people who have concerns). Instead, recognize that some are on different parts of the journey. Retain those who are willing to learn, and to walk the talk, as they grow.
- That being said, the worse the conduct, the more swiftly and decisively you should respond. People whose presence creates risks that you are not willing or able to accept should be corrected or exited immediately. This especially includes leaders like board members, senior management team members, and key external partners.
- Remember that training is educational and helpful to those who are open to learning, and serves as notice to those who are not. Many studies show that training is not helpful. I disagree. Defense Exhibit A in many lawsuits is

the training record showing that the person fired for misconduct was aware of the company's policy on respectful behavior because they took the training. Training helps the organization defend itself, and there is value in that.

Conflict can be healthy. However, employers should seek to prevent it from spiraling out of control. They can do so by encouraging respectful speaking up by employees and other partners, not just officially but also to each other. Create a work environment that allows everyone to express their concerns and fears respectfully and safely.

In sum, do the work that a substantive diversity, equity and inclusion program demands. It is harder work for some than others. In the end, however, everyone benefits; the organization most of all.

About the author

Katrina Campbell is the Chief Ethics and Compliance Officer for Relief International, a humanitarian aid organization.

Footnotes

[1]https://fortune.com/2022/05/23/female-ceos-fortune-500-2022-women-record-high-karen-lynch-sarah-nash/

[2]https://fortune.com/2022/05/23/meet-6-black-ceos-fortune-500-first-black-founder-to-ever-make-list/

[3]https://fortune.com/2022/08/22/women-are-increasingly-being-hired-for-cfo-roles-this-year-says-an-executive-search-firm-president/

[4]https://www.weforum.org/agenda/2022/10/the-diversity-backlash-here-s-how-to-resist-it/

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A Primer on Medicare Graduate Medical Education Payments: What Hospitals Should Know About How the Government Calculates GME Reimbursement

James A. Robertson

John W. Kaveney

Paul L. Croce

by James A. Robertson, John W. Kaveney and Paul L. Croce

In fiscal year 2020, Medicare paid over $16 billion to hospitals throughout the United States in the form of Graduate Medical Education (GME) payments. This article is intended to serve as both a primer covering the basic details of Medicare GME payments, and as a reminder to hospitals that understanding the methodology by which those reimbursements are calculated can potentially open the door to successful court challenges of reimbursement determinations.

Eligibility for GME Payments

A hospital is eligible for GME payments if it is a teaching hospital (often affiliated with a medical school) with an approved and accredited residency program in medicine, osteopathy, dentistry or podiatry.

Purpose of Medicare GME Payments

Medicare GME payments cover Medicare's share of the costs of a hospital's medical residency program. Those costs are broken down into two components: (1) the *direct* costs of operating a residency program, including stipends, supervisory physician salaries, and other administrative costs; and (2) the *indirect* costs of operating a residency program which may result in higher patient care costs in teaching as opposed to non-teaching hospitals, such as additional tests that residents may order as a result of their training.

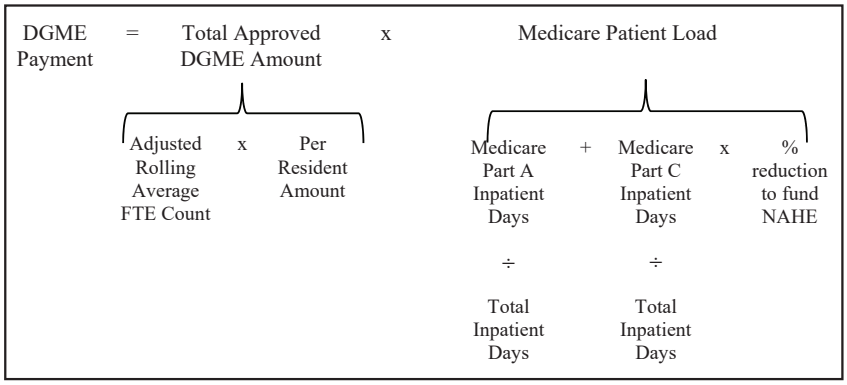
How Does Medicare Pay for GME?

Medicare makes separate payments for direct GME (DGME) and indirect GME (IME) costs. Both DGME and IME payments are determined by a statutory formula. GME payments are not unlimited. Congress caps Medicare GME payments by placing limits on the number of resident full-time equivalents (FTEs) and the per resident amounts (PRAs) it will support. The number of FTEs is capped at the number of FTE residents a hospital was training in 1996. The amount Medicare will pay for an FTE is based on a hospital's costs for a resident FTE in a base year (either 1984 or 1985) as updated by an annual inflation factor.

Direct Graduate Medical Education (DGME)

DGME payments are "pass-through" payments, not an adjustment to Medicare payments for individual hospital discharges. DGME payments are the product of a hospital's total approved DGME costs, which is a three-year rolling average of FTEs (subject to the FTE cap) multiplied by the PRA, which is then multiplied by a hospital's Medicare patient load percentage. A hospital's Medicare patient load percentage is the ratio of Medicare inpatient days to all patient days for the year. In addition, the Medicare Advantage (Part C) portion of a hospital's patient load is reduced by a specified percentage to fund nursing and allied health education (NAHE).

Expressed as a formula, DGME payments are calculated as follows:



The FTE cap and PRAs are hospital-specific, however qualifying hospitals may enter into an affiliate agreement which allows a group of hospitals to share and/or redistribute FTEs among the group, allowing some affiliated hospitals to reduce their Medicare-supported FTEs so that other affiliated hospitals may increase theirs without exceeding the aggregate number of FTEs of the affiliated group. In fiscal year 2020, Medicare paid $4.5 billion for DGME, supporting 88,247 FTEs.

Indirect Medical Education (IME)

IME payments are intended to cover the cost of "inefficient care" provided by residents in teaching hospitals as compared to non-teaching hospitals and are provided as an adjustment to each Medicare inpatient prospective payment system (IPPS) per-discharge payment. IME payments are add-ons to both the operating and capital portions of IPPS payments. In fiscal year 2020, Medicare paid approximately $11.68 billion for IME, supporting 98,542 FTEs.

The IME adjustment to the operating portion of the IPPS payment is based on a statutory formula, which captures for each teaching hospital the ratio of interns and residents to beds (IRB) and applies an exponent to the IRB (0.405) which estimates the effect of teaching activity on hospital costs. In addition, the formula contains a multiplier (of 1.35) which is set by Congress in the statute, which represents a 5.5% increase in the IME payment for every 10% increase in the IRB ratio.

Expressed as a formula, the IME operating adjustment is as follows:

$$\text{IME Operating Adjustment} = 1.35 \times [(1 + \text{IRB})^{0.405} - 1]$$

The IME adjustment for the capital portion of the IPPS payment is based on the residents-to-average daily census ratio (RADC) and an estimate of the effect of teaching activity on hospital costs (0.2822).

Expressed as a formula, the IME capital adjustment is as follows:

$$\text{IME Capital Adjustment} = [e^{(0.2822 \times \text{RADC})} - 1]$$

Increasing Medicare-Supported Residency Position

As of this writing, a teaching hospital's options to increase its number of Medicare-supported residency positions are limited. One method for doing so is for a hospital with an existing residency program to establish a "new" program, which is defined in regulation. A second method is for a hospital without a residency program to start one. Additionally, an urban hospital can start a new Rural Training Track to train residents in a rural area. The final method is for Congress to enact legislation to increase the number of Medicare-supported residency positions. In fact, Congress recently increased new Medicare-supported GME positions by 1,000 slots. Phasing in 200 slots per year over five years, the distribution of these new residency positions will prioritize teaching hospitals in rural areas, hospitals training residents over their cap, hospitals in states with new medical schools, and hospitals that care for underserved communities.

Recent Successful Hospital Appeal in *Hershey Medical Center v. Becerra*

In the recent United States District Court case of *Milton S. Hershey Medical Center v. Becerra,* Civil Action No. 19-2680, a number of teaching hospitals challenged one of the elements that the Secretary of Health and Human Services (HHS) used in fiscal years dating back to 2005 to determine a hospital's DGME payment: specifically, each hospital's weighted number of FTE residents. After students graduate from medical school, they often continue their training in an initial residency period (IRP) which, by statute, is defined to last five years.[i] Some residents additionally complete a fellowship which typically occurs outside the 5-year IRP. Under the Medicare statute, the rules for calculating the weighted average number of FTEs are required to provide a weighing factor of 1.00 for a resident who is in the resident's IRP, and a weighing factor of .50 for a resident who is not in the resident's IRP.[ii] Thus, the Medicare statute requires that a *resident's* time be fully counted but only one-half of a *fellow's* time be counted for purposes of the FTE calculation.

In addition, in 1997, Congress amended the Medicare statute to set a limit on how many FTEs a hospital may factor into its count before application of the weighing factors. That limit was capped at the hospital's 1996 levels.

In 1998, the HHS Secretary amended the agency's regula-

tion which effectively reduced the weighted number of FTEs a hospital may claim for reimbursement when the hospital's unweighted FTE count exceeds its 1996 cap.[iii] When a hospital exceeds the cap, its weighted FTE count is reduced commensurate with the amount by which the hospital exceeds the cap. As the *Hershey* Court explained, assuming a hospital's cap of 100 which is met by employing 90 residents and 10 fellows, after weighing the fellows at 0.5, the hospital's post-weighted FTE count is 95. The math is as follows:

$$\frac{100}{100} \times 95 = 95$$

However, if that hospital adds ten more fellows (for a total of 90 residents and 20 fellows), thereby exceeding the cap, its post-regulation weighted FTE count is reduced to 90.91. The math is as follows:

$$\frac{100}{110} \times 100 = 90.91$$

Recognizing, under the rules of statutory construction set forth in *Chevron v. Nat'l Resource Defense Council,*[iv] that it owed no deference to the HHS Secretary's interpretation of the Medicare statute because the statutory language speaks to the precise issue and is clear, the Hershey Court held that the express text of the Medicare statute did not give the Secretary the latitude to decide, when a hospital exceeds its cap or not, to change the weights that Congress assigned to residents and fellows when calculating the FTE residents for each hospital. Consequently, the Court struck down the agency's regulation, and thus, the DGME calculation, because it violated the express language of the Medicare statute.

Conclusion

With billions of dollars going each year to hospitals throughout the United States for GME payments, and with Congress increasing the number of available GME slots, hospitals are wise to pay close attention not only to the means of calculating DGME and IME, but also how the federal government applies these formulae each year, and how the new GME slots are to be allocated. Now more than ever, courts seem receptive to challenges by providers taking issue with how the federal government calculates reimbursement for GME and other federal healthcare programs. As a result, aggrieved hospitals are in as good a position as they have ever been to challenge the methodology and calculations made to determine hospital reimbursement. Thus, hospitals should continue to monitor how the federal government carries out its responsibilities under the Medicare statute to ensure its actions are consistent with the law.

About the Authors

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Footnotes

[i] *42 U.S.C. § 1395ww(h)(4)(C); 42 U.S.C.§1395ww(h)(5)(F).*
[ii] 42 *U.S.C. § 1395ww(h)(4)(C).*
[iii] 63 *Fed. Reg.* 26,318, 26,330 (May 12, 1998); 42 *C.F.R. § 413.79(c)(2)(iii).*
[iv] 467 *U.S.* 837 (1984).

•Who's Who in NJ Chapter Committees•

2022-2023 Chapter Committees and Scheduled Meeting Dates

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

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

COMMITTEE	PHONE	DATES/TIME/ ACCESS CODE	MEETING LOCATION
CARE (Compliance, Audit, Risk, & Ethics)			
Chair: Fatimah Muhammad – fmuhammad@saintpetersuh.com	(732) 745-8600 Ext. 8280	First Thursday of the month	Conference Call
Co-Chair: Ryan Peoples – RPeoples2@virtua.org		9:00 AM	(667) 770-1460
Board Liaison: Fatimah Muhammad – fmuhammad@saintpetersuh.com	(732) 745-8600 Ext. 8280	Access Code 473803	
Communications / FOCUS			
Chair: Jill Squiers – Jill.Squiers@AmeriHealth.com		First Thursday of each month	Conference Call (667) 770-1479
Board Liaison: Brian Herdman – bherdman@cbiz.com	(609) 918-0990 x131	10:00 AM Access Code: 868310	In-person Meetings by Notification
Education			
Chair: Hayley Shulman – hshulman@withum.com	(973) 532-8885	Second Friday of the Month	Zoom Meeting
Co-Chair: Sandra Gubbine – Sandra.Gubbine@atlanticare.org	(609) 484-6407	9:00 AM	(646) 876-9923
Co-Chair: Lisa Weinstein – lisa.weinstein@bancroft.org	(856) 348-1190	Access Code: 89425417190	via Zoom
Board Liaison: Kim Keenoy – kim.keenoy@bofa.com	(732) 321-5935		
Certification (Sub-committee of Education)		See Schedule for	
Board Liaison: Chair: Amina Razanica – arazanica@njha.com	(609) 275-4029	Education Committee	
FACT (Finance, Accounting, Capital & Taxes)			
Chair: Alex Filipiak – Alexander.Filipiak@rwjbh.org	(732) 789-0072	Third Wednesday of each month	Conference Call
Co-Chair: Hanna Hartnett – Hanna.Hartnett@atlentcare.org	(609) 569-7419	8:00 AM	(872) 240-3212
Board Liaison: Dave Murray – dmurray@rumcsi.org	(856) 298-6629	Access Code: 720-430-141	via GoToMeeting
Institute 2023			
Chair: Michael McKeever – m.mckeever2@verizon.net	(609) 731-4528	Last Monday of each month	Zoom Meetingl
Co-Chair: Sandy Gubbine – Sandra.Gubbine@Atlanticare.org	(609) 484-6407	1:30 PM	
Board Liaison: Heather Stanisci – Hstanisci@annuityhealth.com	(862) 812-7923		
Membership Services/Networking			
Chair: Nicole Rosen – nrosen@acadia.pro	(862) 325-5906	Third Friday of each month	Conference Call
Co-Chair: John Byrne – JByrne56@gmail.com	(917) 837-2302	9:00 AM Access Code: 267693	In person Meetings
Board Liaison: Heather Stanisci –Hstanisci@annuityhealth.com	(862) 812-7923	Call Line (667) 770-1400	by notification
Patient Access Services			
Chair: Daniel Demetrops – ddemetrops@medixteam.com	(845) 608-4866	Second Thursday of each month	Conference Call
Co-Chair: Jacqueline Lilly – jacqueline.lilly@atlanticare.org	(609) 484-6408	at 4:00PM	(712) 770-5377
Board Liaison: Amina Razanica – arazanica@njha.com	(609) 275-4029	Access Code: 196273	
Patient Financial Services			
Chairman: Marco Coello – mcoello@affiliatedhmg.com	(973) 390-0445	Second Friday of each month	Conference Call
Co-Chair: Steven Stadtmauer – sstadtmauer@csandw-llp.com	(973) 778-1771 x146	10:00 AM	(667) 770-1453
Co-Chair: Maria Facciponti – maria.facciponti@elitereceivables.com	(973) 583-5881	Access Code: 120676	
Payer/Provider Collaboration			
Chair: Tracy Davison-DiCanto – tracy.Davison-DiCanto@scasurgery.com	(609) 851-9371	Contact Committee	
Board Liaison: Lisa Maltese-Schaaf – LMaltese-Schaaf@childrens-specialized.org	(732) 507-6533	for Schedule	
Physician Practice Issues Forum			
Chair: Michael McLafferty – michael@mjmaes.com	(732) 598-8858	Third Wednesday of the Month 8:00 AM	Wilentz, Spitzer &
Board Liaison: Erica Waller – erica.waller@pennmedicine.upenn.edu	(609) 620-8335	In person with call in available	Goldman offices
		via WebEx (Contact Committee)	940 Wppdbrodge Cemter. Woodbridge, NJ
Regulatory & Reimbursement			
Chair: James OConnell – OConnellJ@ihn.org		Third Tuesday of each month	Conference Call
Co-Chair: Paul Croce – pcroce@greenbaumlaw.com	(973) 577-1806	9:00 AM	(667) 770-1419
Board Liaison: Scott Besler – scott.besler@toyonassociates.com	(732) 598-9608	Access Code: 382856	
Revenue Integrity			
Chair: Tiffani Bouchard – tbouchard@panaceainc.com	(651) 272-0587	Second Wednesday of each month	Conference Call
Co-Chair:: Nicole Tuesday-Wright – venntuesday@revuhealthcare.com	(848)-391-0075	9:00 AM Access Code: 419677	(667) 770-1275
Board Liaison: Jonathan Besler – jbesler@besler.com	(732) 392-8238		
CPE Designation			
Chair: Lew Bivona – lewcpa@gmail.com	(609) 254-8141		

•Focus on Finance•

AHA Releases 2019 Community Benefit Report Applicable to Tax-Exempt Hospitals

By Bill Hemmer, CPA and Timothy White, MSA

Q. What information was released within the 2019 AHA Community Benefit Report that my hospital organization can use for national benchmarking?

A. The American Hospital Association ("AHA") released its annual report summarizing community benefits provided by tax-exempt hospitals, as reported on the Internal Revenue Service ("IRS") Form 990, Schedule H. In its most recent report released in June 2022, AHA contracted with Candid (formerly Guidestar) to create a file of all electronically submitted Schedule H forms reported by tax-exempt hospitals in the 2019 tax year ("AHA 2019 Report").

A total of 2,372 Schedule Hs were included in the AHA 2019 Report, representing 2,907 hospitals. Together, in 2019 these tax-exempt hospitals accounted for over $110 billion in total community benefits (as defined by the AHA), which represents an increase of $5 billion from the previous year. Approximately half of the $110 billion resulted from expenditures for financial assistance to patients; Medicaid shortfall and other unreimbursed costs from means-tested government programs with the exception of any Medicare shortfall.

A total of 2,372 Schedule Hs were included in the AHA 2019 Report, representing 2,907 hospitals.

Background

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

Together, in 2019 these tax-exempt hospitals accounted for over $110 billion in total community benefits (as defined by the AHA), which represents an increase of $5 billion from the previous year.

IRS Form 990 Schedule H, Part I; Community Benefit

The AHA 2019 Report revealed that hospitals spent an average of 10.5 percent of total expenses attributable to community benefit under the IRS definition, commonly referred to as the "community benefit percentage". This information is summarized on Schedule H, Part I, and includes the expense of providing financial assistance at cost, Medicaid shortfall, funding community health improvement services, underwriting health professions education, funding health research, subsidizing certain health services and making cash/in-kind contributions for community benefit. Note that these expenses and resulting percentages are reported net of associated offsetting revenue and remuneration.

Hospital Category	Financial Assistance, Unreimbursed Medicaid, Unreimbursed Costs from Means-Tested Government Programs	Health Professions Education	Medical Research	Cash And In-Kind Contributions to Community Groups	Other	Total Financial Assistance and Other Community Benefits
All Filed Schedule Hs (2,907 hospitals)	6.4%	1.7%	0.5%	0.4%	1.5%	10.5%

This information is further analyzed within the AHA 2019 Report by hospital size, location and type.

Size: Hospitals were then categorized by size, in terms of total hospital expenses, as follows:

- Small hospitals – less than $100 million
- Medium hospitals – $100 million to $299 million
- Large hospitals – $300 million and more

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

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

For all categories, the majority of community benefit expense is derived from providing financial assistance, Medicaid shortfall and the unreimbursed costs from other means-tested government programs (excluding Medicare shortfall).

Total Benefits to the Community

The AHA 2019 Report expands the IRS definition of community benefit and provides information with respect to "total

benefits to the community." Total benefits to the community include:

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

For the 2019 tax year, tax-exempt hospitals on average incurred approximately 13.9 percent of their total annual expenses on "benefits to the community," which is comprised on the following page.

The Lown Institute establishes a threshold that hospitals dedicating at least 5.9 percent of overall expenditures to charity care and meaningful community investment are considered to have spent their "fair share" against the purported value of their nonprofit tax exemption.

Size: The data shows a positive correlation between the hospital's size and its average total community benefit expenses. For small hospitals approximately of 11.4 percent of their total expenses represented expenses spent on providing benefits to the community whereas medium hospitals and large hospitals incurred community expenses on providing benefits to the community of approximately 12.6 percent and 14.1 percent, respectively. See chart on next page.

Location: Demographics typically have a substantial impact on a hospital's community benefit and total benefits to the community. Data from the AHA 2019 Report indicated that total benefits provided to the community for Urban/Suburban hospitals was 3.6 percent higher than total benefits provided by Rural hospitals.

Please note that the data outlined on the next page is based upon the Schedule Hs filed for 1,911 single hospitals and does not include group hospital Schedule H information, as the information attributable to individual hospitals within the group cannot be identified.

Type: The AHA 2019 Report indicated that Critical Access hospitals incurred an average of 10.7 percent of their total expenses on benefits to the community, whereas General Medical hospitals incurred an average of 13.5 percent in comparison. Teaching hospitals incurred an average of 13.7 percent and Children's hospitals incurred an average of 14.8 percent.

Children's hospitals had a substantially higher percentage of community benefit expenses when compared to the other hospital types, which is typically attributable to a higher rate of unreimbursed Medicaid. In addition, the AHA 2019 Report indicated that Children's hospitals spent an average of 1.8 percent of their total expenses on medical research, which was higher than any other hospital type. Please note that a single hospital can be in more than one "type" category outlined on the next page.

Bad Debt Expense

The AHA 2019 Report revealed that 43 percent of the 2,907 individual hospitals reported bad debt expense attributable to the organization's financial assistance policy. Most hospitals also reported that some portion of their bad debt expense would qualify as community benefit had the patient completed the hospitals' financial assistance processes and provided the requisite financial and other information.

Medicare Surplus and Shortfall

Approximately 72 percent of the 2,907 hospitals reported having a Medicare shortfall on Part III, Section B of Schedule H. This shortfall, which accounted for an average of 3.1 percent of hospital expenses in 2019, occurs when the Federal government reimburses hospitals at less than their costs for treating Medicare patients.

Community Building Activities

Individual hospitals and systems reported an average of 0.1 percent of their total expenses on community building activities. These activities can include workforce development and environmental improvements as well as hospital employee participation on state Boards of Health, regional health departments, neighborhood community relations committees, and with university and other school partnerships.

Scrutinizing Tax-Exempt Hospitals' Community Benefit – The Lown Institute Report

In April 2022, the Lown Institute released its Lown Institute Hospitals Index, a report that ranks community benefit spending for 275 nonprofit hospital systems nationwide against the estimated value of the hospitals' tax exemption.

The Lown Institute report calculated each nonprofit hospital system's "fair share" of spending on charity care and community investment activities as compared to the estimated value of the system's tax exemption. The results showed that 227 of the 275 nonprofit hospital systems spent less on charity care and community investment than the estimated value of the system's tax exemption.

Upon examining the methodology used behind the report, it is clear that the Lown Institute cherry-picks certain categories of community benefit while ignoring others. For example, the Lown Institute argues that Medicaid shortfall is not included in their calculations because hospitals also offer discounted rates to private insurers, which is not considered community benefit. However, the report fails to acknowledge that the Medicaid rates of reimbursement are already substantially lower compared to private insurers. This idea is in direct con-

flict with the IRS community benefit standard as outlined in Rev. Rul. 69-545. Under Rev. Rul. 69-545, tax-exempt hospitals demonstrate community benefit by providing medical care for all patients able to pay, including those who pay their bills through public programs such as Medicaid and Medicare. As a result, tax-exempt hospitals relieve the government's burden by absorbing underpayments from these means-tested government programs.

The Lown Institute establishes a threshold that hospitals dedicating at least 5.9 percent of overall expenditures to charity care and meaningful community investment are considered to have spent their "fair share" against the purported value of their nonprofit tax exemption. However, it is worth noting that the data used to calculate this threshold is a decade old, and includes 2012 IRS Forms 990 data, 2012 CMS hospital cost reports, 2012 AHA Annual Survey data, a pre- Tax Cuts and Jobs Act corporate tax structure and other dated information. Following Lown's release both this year and last year, the AHA issued a response; this year's is entitled "Lown Institute Report on Hospital Community Benefits Misses Mark."

Withum's Healthcare Services Group agrees with AHA and also believes that the Lown Institute report does not capture the complete picture of a tax-exempt hospital's community benefit, which is better reflected by referring to a hospital's most recently filed Form 990, Schedule H.

Conclusion

AHA's annual community benefit report is a useful resource available to all tax-exempt hospitals, which can be utilized to benchmark and compare a hospital to national averages. While this report provides quick comparisons, it is important to note that each hospital has a different set of facts and circumstances to consider, including size, location and hospital type, which can affect its community benefit percentage in relation to its peers.

Community benefit data, hospital operations/activities and reporting transparency continue to be key areas of focus for all users of the Form 990. The IRS, Department of Health, state and local regulators, researchers, and the general public utilize Candid (formerly Guidestar) and other publicly available information to review tax-exempt hospitals' total benefits to the community. Additionally, reports related to community benefit and the value of tax exemption continue to be released by the media and organizations, such as the Lown Institute.

It has become more important than ever that hospitals and healthcare systems regularly monitor and quantify their annual community benefit. In order to do so in the most effective and efficient way possible, Withum recommends the following:

- Consider forming a community benefit committee.
- Compare your most recent community health needs assessment ("CHNA") in conjunction with Schedule H for new activities, programs and initiatives.
- Incorporate other recent Schedule H developments into your Schedule H including social determinants of health ("SDOH"); previously listed under community building activities which improve health and certain subsidized health programs.
- Benchmark your hospital(s) to its peers, both nationally and regionally, and by size.
- Calculate your net community benefit costs and percentage using methods other than CHA, including AHA and state reporting (where applicable) and disclose this information in Form 990 Schedule H or Schedule O.
- Consider a written community benefit statement to include with your annual Form 990.
- Review your Form 990 with your audit committee annually, including your Schedule H and applicable benchmarking information.
- Ensure key individuals of your organization are aware of your net community benefit costs and percentage and applicable benchmarking comparisons, including senior management and Board members.

AHA's annual community benefit report is a useful resource available to all tax-exempt hospitals, which can be utilized to benchmark and compare a hospital to national averages.

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

About the authors

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Benefits to the Community

Hospital Category	Financial Assistance and Certain Other Community Benefits	Community Building Activity	Medicare Shortfall	Bad Debt Expense Attributable to Financial Assistance	Total Benefits to the Community
All Filed Schedule Hs (2,907 hospitals)	10.5%	0.1%	3.1%	0.3%	13.9%

Size of Hospital

Hospital Size	Financial Assistance and Certain Other Community Benefits	Community Building Activity	Medicare Shortfall	Bad Debt Expense Attributable to Financial Assistance	Total Benefits to the Community
Small	8.9%	0.1%	1.7%	0.7%	11.4%
Medium	9.1%	0.1%	3.0%	0.5%	12.6%
Large	10.9%	0.1%	2.8%	0.3%	14.1%

Hospital Location

Hospital Location	Financial Assistance and Certain Other Community Benefits	Community Building Activity	Medicare Shortfall	Bad Debt Expense Attributable to Financial Assistance	Total Benefits to the Community
Rural	7.9%	0.1%	1.5%	0.6%	10.1%
Urban/Suburban	10.5%	0.1%	2.8%	0.4%	13.7%

Type of Hospital

Hospital Type	Financial Assistance and Certain Other Community Benefits	Community Building Activity	Medicare Shortfall	Bad Debt Expense Attributable to Financial Assistance	Total Benefits to the Community
General Medical	10.1%	0.1%	2.9%	0.4%	13.5%
Children's	14.4%	0.1%	0.2%	0.1%	14.8%
Teaching	10.7%	0.1%	2.6%	0.3%	13.7%
Critical Access	9.0%	0.1%	1.0%	0.6%	10.7%

•Committee Corner•

Spotlight on the Membership Services and Networking Committee

Michael P. McKeever

by Michael P. McKeever, CPA, FHFMA

With the start of the pandemic back in the spring of 2020 the role of the Chapter's Membership Services and Networking Committee changed drastically. While still engaged in encouraging growth and retention, they needed to pivot to a virtual means of providing opportunities for networking for the members, as in-person activities were no longer possible. As so many of you know, they did an excellent job arranging numerous virtual events that were both creative and fun. And since these events were virtual, we could easily invite members from other Chapters. These events were so successful that they formed the basis for the submission which earned Region 3 the HFMA Success Award for Engagement, which was announced at the Leadership Training Conference in April. Region 3 (comprised of the New Jersey chapter plus the four Pennsylvania chapters: Metropolitan Philadelphia, Central, Western and Northeastern) was the only region to receive this prestigious award.

Managing the multiple activities of the Committee are Nicole Rosen, Chair, and John Byrne, Co-Chair. I recently reached out to them with a list of questions regarding their roles in the Chapter, with their answers listed below.

How did you first become involved with the Chapter's Membership Services and Networking Committee?

Nicole: When I first joined the Chapter a few years ago I joined alone and didn't know anyone. I wanted to get involved to meet people and help out. I like event planning so I asked if this particular committee needed help and they were happy to have me. Since I was alone, this was really how I started meeting everyone. I love being part of the committee! The next chapter year they asked me to chair the committee and I was honored.

John: I joined HFMA in 2015 when I transferred my career from the Provider Side to Revenue Cycle consulting. At the same time, my efforts transitioned from 100 percent New York-based to 50 percent working with clients in New Jersey. In addition to learning the New Jersey Turnpike and Garden State Parkway, I wanted to meet people working in healthcare financial management in New Jersey, so I reached out to Laura Hess in early 2016. Laura provided me with great information. I joined the Revenue Integrity Forum and the Membership Services and Networking Committee. Brian Herdman was supportive of getting me involved in Membership Services and Networking. Almost immediately I volunteered to help my now friend and colleague Nicole Rosen to run a Hatchet Throwing Networking Event. This was a wonderful introduction to meeting Chapter members in person.

Tell us a little about yourselves, such as what you do in your daytime job, and how you like to spend your off hours. Is there anything you'd like to share with our readers?

Nicole: I work for Acadia Professional full time. We're a medical malpractice insurance brokerage. We represent every medical professional liability insurance carrier in the area and beyond. We work with physicians and physician practices to help them

with risk management and get the best possible rates on their insurance. I'm the director of new business development! In my off hours I love to go to the beach, travel, workout, do puzzles, cook, and see friends. I recently got married in December 2022 so that took up all of my time lately. Another event to plan!

John: I work as a Mergers and Acquisitions Intermediary, selling and buying healthcare practices and healthcare businesses. Quite a few people in the Chapter have been helpful with information and insights into the healthcare marketplace. I enjoy talking shop with my HFMA New Jersey colleagues.

I am a "COVID Golfer." Prior to the pandemic I never picked up a golf club. Now I try to play at least 9 holes every other week, starting very early before work. Alternate weeks I go to a driving range where I am still learning. What I lack in talent and skill, I make up in enthusiasm!

The pandemic changed so much in our routines, but the Committee was able to quickly pivot to the new virtual reality and allow our members to continue to network from home. Tell us a little about that process.

Nicole: We wanted to be a source of happiness and hope during the pandemic. We quickly incorporated Zoom meetings of many different varieties. We of course did networking Zoom events, but we made sure to do fun Zoom socials such presenting a magician, a cooking class, a sommelier and more. We just thought of what we would like to do in our spare time and what we thought would make people smile and we made it happen. I noticed that people started to have anxiety about going back into offices and to in-person meetings when the pandemic started to lift. I outsourced a licensed life coach and hypnotherapist, Traci Rosen from Tracing Your Path, to come on for a free Zoom presentation to give our members tips and tools and act as a resource during these tough times. I also think that having free virtual meetings/socials/happy hour during that time was a nice thing we were able to do for our valued members.

John: In April 2020, our Committee decided to run a virtual networking event in May 2020 to reconnect members whose work lives had been disrupted by the pandemic before we achieved the "new normal." Nicole, Heather Stanisci, Brian, Laura, Mike McKeever, and Stacey Medeiros were all supportive, generous with time, and contributed a great deal to the success of the first event. We repeated this event in July 2020, and had our first event with another Chapter, the Hudson Valley (New York) Chapter in August 2020. The experience gained from these events helped us to plan the events for the remainder of the program year.

There were so many interesting events over the past 2 years, such as the wine tasting, cooking demonstration, etc. Where did the ideas come from?

Nicole: Some came from other organizations I saw doing events and tried to copy when I found them interesting. A nearby restaurant – Sally G's in Warren, NJ – has a chef who won the Food Network's Chopped Award. I had seen people doing cooking demos, so I had asked him if he could come on and do one for us and even though he never did one before he agreed. It was probably our most successful event to date; people really loved it. He got pretty famous after his big Chopped debut so it's almost impossible to get him now but I'm glad we got him while we could!

John: Our Committee meets monthly. We continually are reinvented by the addition of new members. Our members bring broad experience from their work and from other networking events. Nicole and other committee members have been very good at scouting talent for the demonstrations. We look for presenters who are talented, good communicators and affable.

We're obviously pivoting back to in-person, but can we expect virtual events going forward?

Nicole: Yes, I think virtual events are here to stay in some capacity. We will make sure to mix in virtual events once or twice during the chapter year specifically in the winter when people aren't as thrilled to leave their house. If anyone knows a cool chef willing to do a cooking demo, please let us know because we'd love to do something like that again! However, most actual networking events we found are better in person. We did try breakout rooms via Zoom that were good for when we were locked in our homes, but if we could do these types of events in person we knew they would be more successful.

John: Yes. We are planning several virtual events in this program year. The advantage to virtual events is that we take away the need for travel. For in person events, we need to carefully consider location and travel times. One change for this year, we will be building a networking forum into every virtual event, at the end of the event. We will be encouraging members to meet each other and starting professional dialogue that can continue beyond the event.

This committee has two separate but equally important roles. Tell us a little about how we onboard new members, and what we do to encourage their engagement?

Nicole: John mostly handles this aspect of the committee so I'd defer to him on this one; however, we have always suggested that during the annual institute we should have some sort of session with new members and seasoned members so they can meet and learn about the chapter and what's available. Before I became a member, I went to an Annual Institute, and I didn't

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NJ Medicaid Resumes Eligibility Determinations April 1

Jennifer Langer Jacobs

by Jennifer Langer Jacobs

It's been about a thousand days since any New Jersey resident lost NJ FamilyCare health care coverage. Soon, however, that's going to change. Beginning April 1, 2023, New Jersey's Medicaid program will resume eligibility re-determinations. We know how to do this work and we have teams across the state prepared to do it, but we will be doing it at an unprecedented scale with a community that hasn't needed to engage in this process since the pandemic began. Throughout it all, our number one priority will be helping residents through this process and protecting anyone who remains eligible for this program from unnecessarily losing their benefits.

Taking a quick step back: In 2020 when the COVID-19 pandemic began, Congress passed the Families First Coronavirus Response Act. The law provided additional funding to Medicaid programs and instructed them to provide continuous coverage to Medicaid members as long as the PHE remained in effect. Unexpectedly, the PHE continues three years later and, as a result of the continuous coverage policy, Medicaid enrollment in New Jersey and other states has grown by more than 30 percent.

The omnibus bill signed into law in December 2022 now requires states to restart Medicaid eligibility reviews nationwide. In this extremely important time, states must re-determine eligibility for more than 90 million Americans over a twelve-month "unwinding" period – and we will do so for more than 2 million in New Jersey alone.

Here in New Jersey, we want to handle the "unwinding" period in the best way possible. This includes resuming Medicaid eligibility determination processes with updated technical systems, a public awareness campaign, and support from community partners – especially our partners in the healthcare space.

We are taking care to ensure that State and county agencies have time to carefully review each member's eligibility. We will be sending renewal letters to a portion of our membership each month for the twelve months following April 1, 2023. Members who responded to prior mailings will stay on their current schedule. For example, if a member got a renewal letter in November 2022 and responded, they will get their next renewal in November 2023 – a year after their last one. Members who did not respond to prior mailings will be spread evenly across the year.

It Takes a Village to End a Pandemic

Among other things, the pandemic reminded us that communities can provide essential support and protection for one another. Over the course of the pandemic, our healthcare community mobilized against seemingly impossible odds, distributing equipment for infection control, advancing new clinical protocols, exploring frontiers in telehealth, delivering vaccinations, and addressing unprecedented health-related social needs of our broader communities.

Now, as this important eligibility work begins, we need ongoing community partnership to get the word out and help people understand what is happening next with NJ FamilyCare coverage.

NJ FamilyCare has launched a public education campaign, StayCoveredNJ, at nj.gov/staycoverednj, to inform New Jerseyans about the upcoming process. We have two messages for our members:

- Please update your contact information so that we can contact you when it's your turn to renew your NJ FamilyCare coverage.
- Please respond promptly to any mail you get from NJ FamilyCare.

We have, of course, reached out to our members, but we are also depending on the support of health care providers, schools, day care centers, cultural groups, food pantries, and many other community partners.

You work in healthcare. You get it. People need coverage. So how can you help?

Health care providers have a special role as a trusted source of health information. There is no better time to discuss the importance of remaining insured, healthy, and safe than when a patient receives medical care. Each day, staff have the opportunity to remind patients about renewal of their NJ FamilyCare/Medicaid coverage.

Please talk to patients about updating their contact information with NJ FamilyCare and responding promptly to our mail. When a patient with NJ FamilyCare coverage reports a new address to your office, please tell them to call 1-800-701-0710 (TTY: 711) to update their address with NJ FamilyCare too.

To help us get the word out, you can visit our StayCoveredNJ website right now. There, you'll find printable materials including posters in 19 languages and Frequently Asked Questions. Please post materials in a spot that is visible to the people we mutually serve – reception desks and waiting areas are ideal locations. You can also email us at DMAHS.CommunityCollab@dhs.nj.gov to ask for a print run of posters – we're happy to provide them.

And finally, please be a true partner and email us at the address above with any concerns you have or questions you are getting about Medicaid eligibility re-determination. As always, our partnership is essential and so very much appreciated. Together, we will do this the best way possible.

About the author

Jennifer Langer Jacobs is the Assistant Commissioner for the New Jersey Department of Human Services' Division of Medical Assistance and Health Services.

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know anyone and actually ate dinner alone in my room. It would have been nice to meet people as a new member coming alone so we incorporated that this year at the Annual Institute before the Charity Event.

John: We reach out to all new Chapter members by email the month after they join—introducing them to the Chapter and its Committees/Forums. We also invite them for one-to-one conversations to learn about them, their interest in HFMA and what they do. This year we have been expressly inviting new members to attend our in-person networking events.

In talking with new members, do we get a sense of just what they expect from their HFMA membership?

John: New members want to know how they can fit in. We spend time going over the different Committees/Forums, when they meet, who the Chairs/Co-Chairs are. New members have different interests, but all are looking for professional development and networking.

What would you say to someone considering joining HFMA to convince them of the value of membership?

Nicole: It's a great opportunity to meet great people from the industry. I started as a younger person new to healthcare and after a little while I met great people who really helped me. Some people I met have been in the industry for a while and were able to give me great advice. Also, as someone in sales, I got a client directly from one of our networking events. I also met people who work with like clients and have referred people to me which is the best thing that could possibly happen. Lastly, as you progress in your career, the more people you know, the more opportunities you have!

John: All professionals including healthcare financial management professionals need to make a commitment to professional growth through structured reading, continuing education, and forums in which they can learn. All professionals need to develop their professional networks, particularly for opportunities to exchange information, to be exposed to new ideas and programs, and to meet other professionals. HFMA membership can be one of the strategies for fulfilling all of these goals.

Annual Holiday Social 2022

Save the Date….

Annual NJ HFMA Golf Outing

Thursday, May 11th, 2023, 1PM shotgun start

Mercer Oaks
West Windsor Township, NJ

Prizes and raffles!

More Information Available Soon!