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DEADLINE FOR SUBMISSION OF MATERIAL

Issue Date	Submission Deadline
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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.

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Scott Besler
scott.besler@atlanticare.org

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The President's View . . .

Heather Stanisci

Dear NJ HFMA Members,

I am honored to serve as the President of the New Jersey Healthcare Financial Management Association for the chapter year 2023-2024. As we stand on the cusp of this exciting period, I want to express my gratitude for the trust you have placed in me to lead our esteemed organization.

As we embark on this new chapter year, let us reflect on the chapter's growth and accomplishments that are a testament to the dedication and expertise of our leadership and members. Together, we have shaped the NJ HFMA into a community that thrives on collaboration, professional development, and a commitment to excellence.

This year, our chapter focus is increasing Education Value and growing member and volunteer engagement. To achieve these goals, we will focus on utilizing innovative social media outreach, continuous learning, and collaboration. Through this focus, we aim to create a chapter that fosters meaningful connections and empowers each member to reach new heights in their healthcare financial management journey.

This September we are proud to host our 47th Annual Institute in Atlantic City which is a unique opportunity for industry leaders, experts, and professionals to engage in thought-provoking discussions, participate in hot topic education sessions, and forge valuable relationships. This multi-day event's agenda, keynote speakers, and presenters promise to create a not-to-miss gathering that will set the tone for the impactful work we aim to accomplish together this year. Our dedicated Institute Committee has diligently worked to ensure that this year's event will be both informative and inspiring.

I am committed to upholding the legacy of NJ HFMA and fostering an environment where all members can contribute, learn, and thrive. Your active involvement is essential to the success of our organization, and I encourage you to engage with our committees, attend our education events, and enjoy our many networking opportunities that we have planned throughout the upcoming chapter year.

Thank you for your ongoing support, and I eagerly anticipate the achievements and growth that we will accomplish together in the coming year.

Warm regards,
Heather Stanisci President, NJ HFMA

From The Editor . . .

James Robertson

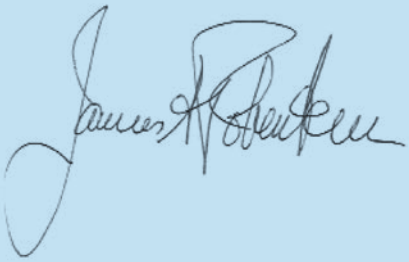
The Communications Committee is pleased to provide you with this year's Annual Institute Edition of Garden State *FOCUS*. We are extremely proud of our FOCUS Magazine which continues to be recognized by the national HFMA organization as **THE** premier publication nationwide among all local HFMA Chapters.

In this Edition, many of our Annual Institute speakers have written articles on the topics they will be presenting at the Annual Institute. For instance, John Kaveney's article on Life After the End of the Public Health Emergency, found on page 19, Scott Bresler's and Fred Fisher's article on the New Medicare Cost Reporting requirements under Transmittal 18, found on page 23, and Wyley McCoy and Fatimah Muhammad's article on Unlocking Revenue Potential by Maximizing Efficiency, found on page 32, are all preludes to their speaking programs on Wednesday afternoon, September 27th. Likewise, Ron Hirsch's article on Bridging the Case Management and Revenue Cycle Gap, found on Page 10, Day Egusquiza's article on Medicaid Redeterminations, found on page 13, and Jack Wenik's update on Recent Developments in Federal and State Fraud and Abuse Investigations, found on page 36, are great teasers for their programs on Thursday, September 28th. These articles and speakers, as well as other experts in the healthcare field, will surely make this Edition of *FOCUS*, and the 47th Annual Institute, a huge success!

Of course, the success of the Garden State *FOCUS* can only be possible by the commitment of so many volunteers who selflessly contribute their time and talent to producing this award-winning magazine for you, our valued members. The current members of the Communications Committee, Brian Herdman, Jill Squiers, Adam Abramowitz, Rachel Gisser, Laura Hess, Elizabeth Litten, Fatimah Muhammad, Amina Razanica, Lisa Weinstein, Mike McKeever, and Stacey Medeiros, work tirelessly to provide you with an informative, well-written magazine containing the most relevant content for your healthcare organizations and careers. In this way, the Communications Committee does its small part to ensure that you receive value through your membership in NJ HFMA.

As the new Editor, I promise to continue the legacy of excellence which had been the hallmark of our past Editors -- people like Elizabeth Litten, Adam Abramowitz, Brian Herdman, Scott Besler and, most recently, Jill Squiers. We thank them for their leadership.

We hope you enjoy this Annual Institute Edition of Garden State *FOCUS*.



Welcome to the 47th Annual Institute

Sandra Gubbine

by Sandra J Gubbine

On behalf of the Annual Institute Committee, welcome to the 47th Annual Institute! We have a diverse agenda with all the latest hot topics! The conference starts at 12noon on Wednesday, September 27th and runs through 12:05pm on Friday, September 29th. Below is your guide to events you won't want to miss.

Education

Attendees have the opportunity to earn **15 CPE credits** over the course of the event. We have exciting speakers each day of the conference including, but not limited to:

- **Wednesday, 12:00pm** – Dennis Dahlin, HFMA National Chair. The Chair's theme, It's Time, is a call to action not only for HFMA and its members but also for the industry at large. Providing a framework for needed changes that will require strategic focus on addressing the cost effectiveness of health (CEoH).
- **Thursday, 9:00am** – Ronald Hirsch, VP, R1 RCM. This session will focus on bridging revenue cycle professionals and case management to work as a cohesive team that fosters clinical and financial integration. As a result, denials will decrease, facilitation of recoupment will increase, and costs will be reduced with improved processes.
- **Thursday, 9:50am –** Day Egusquiza, President, AR systems Inc. The PHE is over and now Medicaid patients must re-apply for their benefits. Will they still qualify, will they know they need to re-apply? Learn what you need to do to prevent havoc at your facility.
- **Thursday, 11:00am** – Robert Garrett, CEO, Hackensack Meridian Health. Don't miss the opportunity to hear Mr. Garrett's insights on the current healthcare landscape.
- **Thursday, 4:10pm** – Revenue Cycle Round Table. Key revenue cycle leaders will discuss complexities of revenue cycle. The panel includes:
  - Christy L. Pehanich, MHSA, FHFMA, CPC, AVP, Revenue Management - Professional Operations at Geisinger Health System
  - Steven Honeywell, MHA, CRCE I/P - University of Pennsylvania Health System
  - Joe Scargle, MBA, Senior VP Revenue Cycle - RWJBarnabas Health
  - Anne Goodwill Pritchett, BS, MPA, FHFMA executive vice president for Network Revenue Operations for Hackensack Meridian Health Hospitals, and the Physician Enterprise.
  - Sandy Gubbine, CPA, MBA, FHFMA, DBA, AVP, Revenue Cycle - AtlantiCare
- **Friday, 10:00am** – Deborah Visconi, MHA, President & CEO and Barbara Piascik, Chief Compliance Officer - Bergen New Bridge Medical Center. Hear how Bergen New Bridge has established itself as a leader in Equity, Diversity and Inclusion.
- **Friday, 10:50am –** CFO Panel – The panel will discuss various topics including Covid 19 response – strategic shift, increasing costs/inflation, recruiting and retention, workforce shortages, financial performance – margin pressures, acquisitions and mergers, regulatory red tape, and capital markets.

We will also have six breakout sessions available spread over Wednesday and Thursday. During each breakout you will have the choice of three to four different sessions that best piques your interest. Topics include Artificial Intelligence, Analytics, Workforce Management, Compliance, Revenue Integrity, Financial Reporting and Revenue Cycle, just to name a few.

Networking

As always, we've got a full slate of networking activities scheduled across the conference to maximize your time with your colleagues.

- **Wednesday Night – Charity Event (5:30pm– 7:30pm, Vendor Hall)** – Heavy hors d'oeuvres, cocktails, wine and beer and a good time will be provided. The event

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How Finance Leaders Can Improve the Bottom Line with Clinical Knowledge

by Dr. Keith Stokes, Dr. Doug Cutler and Glenn Krauss

Dr. Keith Stokes

Dr. Doug Cutler

Glenn Krauss

Introduction

In today's competitive healthcare landscape, hospitals and health systems are perpetually grappling with revenue cycle challenges. A prevalent issue plaguing the industry is the segmented operation of revenue cycle components, a malady of long-entrenched, deep-seated silos that impede open communication and operational transparency. In the midst of this systemic dilemma lies an untapped resource: a virtual diamond mine of unused knowledge and experience within every facility.

The Pursuit of Integration: UR/UM and CDI Shift to Finance

Understanding the rationale behind Utilization Review (UR) / Utilization Management (UM) and Clinical Documentation Improvement (CDI) migrating over to finance is the first crucial step in aligning people, processes, and technology. Finance departments are becoming more intertwined with clinical processes, necessitating a change in traditional operational structures. The convergence of UR/UM and CDI with finance might seem counterintuitive. However, when examined closely, the fusion leads to more informed decision-making processes, better understanding of the revenue cycle, and improved patient outcomes.

Crucial Clinical Knowledge for Finance

Successful revenue cycle management requires a close alignment of financial and clinical perspectives. Finance departments need up-to-date clinical knowledge to accurately evaluate the performance of the revenue cycle. This includes understanding of patient acuity, medical necessity of procedures, and accurate clinical documentation. All these factors contribute significantly to the reimbursement process and the overall financial stability of healthcare institutions.

The Case for UR/UM and CDI Under Finance

While the transition of UR/UM and CDI under finance might spark debates, the benefits of this strategic alignment are multifaceted. By housing these clinical roles under the umbrella of finance, there is potential for enhanced understanding of the interplay between clinical practices and financial outcomes, more accurate revenue forecasting, and improved claim denial management.

Role of CDI & Coding in Supporting Finance

CDI and Coding departments play a pivotal role in strengthening financial performance. Through thorough, accurate documentation and proper coding, these departments can ensure appropriate reimbursements, reducing denials, and fostering efficient revenue cycle processes. By working collaboratively with finance, they can provide invaluable insights into the clinical aspects of the revenue cycle, driving performance and financial stability.

Avoiding the Gray Rhino

Lastly, one cannot ignore the 'Gray Rhino' - a term coined for highly probable yet neglected threats that have a high impact. In our context, this could signify denials. Denials are a substantial obstacle that can derail the revenue cycle. However, with strategic foresight, rigorous processes, and interdepartmental collaboration with the right technology, it is possible to identify and mitigate these looming risks before they run you over.

Conclusion

Achieving seamless communication across different components of the revenue cycle is not a pipe dream. It is not only feasible but essential for improving reimbursements and stream-

lining operations without significant investment in additional software or full-time employees. It requires a fundamental shift in perspectives, moving away from siloed thinking and towards integrated, collaborative practices. It begins with the alignment of people, processes, and technology, augmented by robust reporting mechanisms.

By leveraging the untapped wealth of knowledge and experience within our teams and breaking down long-standing silos, we can pave the way for a future where every function, from UR/UM and CDI to coding and finance, works cohesively towards optimizing revenue cycle performance.

About the Authors

Glenn Krauss is a revenue cycle professional with over thirty years of progressive experience in all aspects of the revenue cycle with an emphasis upon working with physicians in helping them master the art of documentation and charting in the EHR. What sets Glenn apart in the clinical documentation improvement arena is the recognition of clinical documentation effectiveness, accuracy, completeness & contextual consistency as fundamentally integral with all components of the revenue cycle including driving effective outcomes in value-based purchasing payer initiatives and driving down costly self-inflicted payer denials. Glenn can be reached at Glenn.Krauss@Core-CDI.com.

Doug Cutler, MD is a long time practicing hospitalist with extensive experience as a physician advisor, chief medical officer, medical director, and chair of the utilization review committee He possesses a keen understanding of the direct relationship between clinical medicine, the clinical revenue cycle, and the clinical financials of the hospital or health system. As a previous Chief Medical Officer and Medical Director, Dr. Cutler served as the liaison between the clinical side of healthcare and the financials of the hospital working with the CFO. Doug can be reached at dmcutler66@gmail.com.

Keith Stokes, MD, Dr. Keith Stokes is a board-certified physician with a diverse career that includes experience as a clinic medical director, hospital chief of staff, hospitalist, consultant, and physician advisor. He is currently employed as a hospitalist at the University of Mississippi Medical Center, Holmes County. Dr. Stokes performs Peer-to-Peers with payer Medical Directors as part of his hospitalist duties and responsibilities. He has served as a consultant for numerous hospitals, primarily focused in the areas of Case Management, Utilization management, Denials and Appeals, and Clinical Documentation Improvement. Keith can be reached at KStokes@docucompllc.com.

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continued from page 5

will wrap up no later than 7:30pm to ensure attendees have time for dinner with friends and colleagues. This year's Charity Event beneficiary is the Glioblastoma Foundation. Glioblastoma is the most aggressive type of tumor that arises in the brain and is one of the most lethal forms of brain cancer. Because each glioblastoma is different, there is no one therapy that is effective for all cases. The Foundation supports the development of targeted therapies for this fatal disease.

- **Thursday Night – President's Reception (6:00pm – 8:00pm, Borgata Indoor Pool and Garden (weather permitting))** – Entertainment will be provided as well as light hors d'oeuvres and cocktails, wine and beer.
- **Thursday Night – Late Night Event (10:00pm – 1:00am, Premier Nightclub)** – Please join us at one of Atlantic City's most sophisticated nightlife destinations. Meet new people, have some fun and dance the night away with a cocktail!

Thank You!

The Annual Institute would not be possible without our generous sponsors and volunteers. A whole-hearted thank you to all of our vendors who support us, some of which have been with us for years. Additionally, we must thank members of the Institute and Education committees who have provided many volunteer hours into planning this event over the course of the past year. Without all of you, we would not be able to put on an event of this magnitude for our members and friends.

Please enjoy this year's Institute!

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It's Time!

Dennis E. Dahlen

by Dennis E. Dahlen, HFMA National Chairman, Chief Financial Officer of Mayo Clinic

We've all been in situations where the time was right, where conditions were optimal or good enough to suggest the best opportunity for action. Growing up on a dairy farm, I learned early that nature exerted a stronger hand on our schedules and work than anything humans could muster. Weather was, of course, a constant input to a changing schedule, but the natural cadence of planting, harvesting, calving and other tasks all reinforced the importance of taking advantage of times when conditions are best to accomplish what needs to be done. This early conditioning manifests itself in a growing sense of anxiety and impatience when time passes between the right conditions and an appropriate action.

I've lately been feeling that same kind of anxiety and impatience with regard to the healthcare industry. As I begin this year as national chair of HFMA, the industry is facing a unique and interesting set of circumstances that are hard to ignore:

- **Increasing public criticism** of the nonprofit healthcare model, targeting executive salaries, misuse of 340B discounts and provider relief funds, and ignoring the charitable purpose of healthcare for those who can't pay for it. We are losing the hearts and minds of our neighbors, friends and policymakers.
- **Broad financial challenges** being experienced by even the most advantaged industry participants — large integrated health systems. Less advantaged participants face more grave challenges, even existential threats.
- **Increasing flows of investment** into provider capacity by new entrants such as Optum, Amazon, Walgreens and CVS. As established participants, are we living the *innovator's dilemma* in real time?
- **Very exciting accelerations of innovation**, the introduction of digital and *virtual* tools at scale, and significant discoveries in genomics and other sciences to advance cures.
- **Advancement of leveraging data and technology** have real promise to finally move the practice of medicine beyond its almost singular reliance on human effort to provide care.

If you're not feeling the pressure to transform and adapt, you're very fortunate. As an Association whose members serve an industry under duress, HFMA exists at the nexus of industry pressure and opportunity to transform. The Association has always sought to play a pivotal role in improving the current state, and now is the time for us to take that effort to the next level.

Now is the time for all of us, individually and working together as a national organization, to step out and step forward to embrace innovation and visibly advocate for the just cause of CEoH.

We've spent the past couple of years preparing by outlining our cost effectiveness of health (CEoH) strategy, but have yet to fully step into those shoes. We've initiated steps to a global presence, but success is far from certain. HFMA's business model increasingly depends on the support of large-scale industry participants, and it is not immune to industry pressures. Now is the time for all of us, individually and working together as a national organization, to step out and step forward to embrace innovation and visibly advocate for the just cause of CEoH. It seems more clear each day that conditions are optimal for this kind of action. And since it's what HFMA was built for — to lead the financial management of healthcare — we have no choice.

It's time!

Bridging the Gap Between Case Management and Revenue Cycle

Ronald Hirsch

by Ronald Hirsch, MD, FACP, CHCQM, CHRI

The focus of every health care encounter is the patient. Be it for an outpatient visit to receive a recommended cancer screening test, a visit to the lab to get their cholesterol checked, or an unplanned trip to the emergency department for an acute illness which leads to a hospital stay, the patient is counting on every one of us to provide the right care, in the right setting, minimizing the amount of non-productive effort needed by the patient. While one could argue that the patient is responsible for knowing their insurance coverage, their financial obligations, and their payer's requirements to cover that service, the reality is that patients depend on us to do that for them and, after all, we are the experts.

Many have already made the transition to electronic registration at outpatient sites of service. The patient arrives, enters demographic information into a device and is "checked in" for their visit. My personal experience during my last two encounters was anything but easy. The first visit to a freestanding lab center had a system that asked me to place my driver's license on a small platform to be scanned. As I placed the card, the platform fell off and crashed to the ground. The technician who happened to be nearby stated "oh, don't worry, that happens all the time."

My next visit was at a hospital outpatient imaging center. I proceeded to answer all the questions on the screen and then nothing happened. No confirmation of completion, no request for additional information. I noticed at the screen next to mine another patient with the same perplexed look. Fortunately, a registration clerk saw the bewilderment in our eyes, asked for our ID cards, and registered us the old-fashioned way. As I was leaving, I noted someone "rebooting" the self-registration computer screens.

Technology is wonderful, but only if it works. With the perspective of a patient and a physician and an insurance regulatory expert, I would want a registration process that not only works but also allows me to be informed of insurance coverage for my service, if the service has been approved by my insurance or requires prior authorization, and any financial liability I may incur. Naively, it seems to be that if I can take my ATM card to any country in the world and the ATMs there know my bank balance and how much money I can withdraw, I should be able to know my insurance coverage prior to receiving any service at any facility in the country. Is that too much to ask?

"Technology is wonderful, but only if it works. With the perspective of a patient and a physician and an insurance regulatory expert, I would want a registration process that not only works but also allows me to be informed of insurance coverage for my service, if the service has been approved by my insurance or requires prior authorization, and any financial liability I may incur."

For patients who are hospitalized, accurate insurance information obtained at the start of care is used throughout the encounter. Even in emergencies, the payer must be notified of the hospitalization, first to determine if they are at an in-network facility and then to determine the correct admission status. While admission status determinations could be the subject of an article by themselves as there is no standard for deciding which patients warrant inpatient admission and which should be treated as an outpatient in the hospital, usually with observation.

While the care is the same regardless of the patient's admission status, the payment is significantly different. For instance, the Medicare base payment for an outpatient stay with observation is about $2,440 while an inpatient admission for a low

weighted DRG such as chest pain would pay $7,000. But of course, admitting as inpatient when outpatient is the correct status is non-compliant and risks audit, denial, and potentially a referral to the Recovery Audit Contractor (RAC). Ensuring the right payer's rules are used is therefore critical to getting paid for the hospital visit. And depending on the payer, ongoing dialogue between the UR staff and the payer may be required to continue coverage, with some payers going as far as to carve out days from the payment that they unilaterally determined were not "medically necessary."

The increasing age of our patients and need for post-acute services also require accurate insurance information to make arrangements for post-hospital services like a stay at a nursing facility or home care. Incorrect information at the time of registration could lead the case manager to believe that authorization for such services is not necessary when in fact the patient's payer does require them. It is not uncommon to see payers demanding 72 hours to approve such a transfer, leaving the hospital with an occupied bed for which there is no additional revenue.

And while the clinical documentation and coding staff are not directly participating in the care of the patient, their role in ensuring the medical record and the claim comprehensively portray the patient's hospital course is crucial to ensure the many external organizations who are measuring what they consider to be the quality of the care you provide receive the full picture. Every diagnosis, be it the principal diagnosis or one of the many secondary diagnoses, contributes to calculation of risk of mortality, the readmission risk, and the patient's overall complexity that is used in many "value-based" payment systems.

All patients also require complete and timely discharge planning to ensure the patient receives the necessary care after discharge. If the patient's insurance company formulary does not cover the new heart medication ordered by the physician, their risk of readmission due to recurrence increases. If the patient's social determinants of health are not queried and addressed, the patient's risk of relapse and rehospitalization increases. In the "value-based" world, those additional costs may fall back on the hospital in the form of denied payment for a readmission and a poor qualify score resulting in a penalty that is applied for the next three years.

Ensuring the revenue cycle is patient-centered is not a luxury, it is a necessity. Ensuring our patients get the right care in the right setting is the key to a hospital's clinical and financial success.

About the Author

Ronald Hirsch, MD is vice president of regulations and education for R1 RCM Inc. He is on the national advisory committee for the American College of Physician Advisors and the National Association of Healthcare Revenue Integrity and the co-author of The Hospital Guide to Contemporary Utilization Review. Dr. Hirsch can be reached at rhirsch@r1rcm.com.

•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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Smile Train

Outsmarting the Moving Denials Target

Christine Fontaine

by Christine Fontaine

The past few years have drastically reshaped the healthcare landscape and affected denial rates. Challenges for healthcare organizations continue to evolve at a rate with which it is hard to keep pace. Between workforce shortages and antiquated technology, it can be difficult for your healthcare organization to stay updated with the latest rules, regulations, and codes that seem to appear with little warning. For revenue cycle teams to succeed in today's healthcare landscape and mitigate denials effectively, they must be equipped to navigate a constantly changing environment while maintaining revenue stability, reducing the risk of denials, and protecting cash flow.

There's little margin for error or waste when it comes to outsmarting the moving denials target. Recent research conducted by the Healthcare Financial Management Association reveals that healthcare organizations that devote greater resources to denials prevention have lower first-pass denial rates — yet only 17.3% of those surveyed devote those resources.

So, how can providers form a proactive approach and work smarter when it comes to denial prevention and management? At the top level, it's important to:

There's little margin for error or waste when it comes to outsmarting the moving denials target.

1. Allocate denials for smart follow-up

Using automated solutions powered by AI and RPA allows you to automatically triage and prioritize denials, identifying those with the highest likelihood of being overturned on appeal without needing to waste valuable staff time and energy.

2. Automate front to back processes

With an automated set of solutions, ideally operating through a fully unified RCM platform, supporting front-to-back processes, you can leverage machine learning and AI to contrast expected and actual outcomes to outline weakness in your revenue cycle and establish targets for realistic process improvements.

3. Avoid write-offs across all channels

The real key to improving your long-term strategy for avoiding denials is understanding the root causes behind your most persistent issues. Analytics and dashboards can give team leaders high-level insight into those issues with reporting on key performance indicators that identify the departments and processes that need the most help and attention to structure ongoing improvements.

The path to fewer denials

While providers may find themselves strongly challenged by the uphill climb to achieve a better denial rate, new strategies and solutions have already arrived that make achieving their goal more attainable than ever before.

Smart, streamlined workflows that give teams the ability to easily edit and resubmit denied claims; customized workgroups that automatically route denials to the right team; robust reporting, stronger analytics and automation that drastically improves productivity — they all add up to a smarter, simpler approach to manage denials and, in many cases, even prevent denials before they happen.

About the Author

Christine Fontaine is a Solution Strategist with over 20 years' experience in the healthcare finance field, managing revenue cycle operations at both physician and hospital business offices. She specializes in identifying solutions to help organizations optimize their revenue cycles. Christine can be reached at Christine.Fontaine@waystar.com.

The Medicaid Redetermination – Hanging Off The Edge of The Cliff

Day Egusquiza

by Day Egusquiza

Many had predicted that there would be a large group of existing Medicaid patients who would not requalify for Medicaid once the redetermination/rescreening had begun. It was thought the largest group would move to commercial insurance (over the last 3 years, had started a job that offered insurance) with the remainder who did not qualify being moved to the Marketplace/Exchange with assistance with premiums and deductibles for lower income enrollees earning too much for Medicaid but not able to afford regular insurance.

What was likely greatly understated was the way that each of the states could decide on their own process for screening which group to do 'auto', which group to do first, etc. and that the majority of the 'rejections for coverage' would be from what is referred to as procedural/administration issues. Wow- the volume of patients being moved off coverage is astounding. How will the patient know how to get re-evaluated for coverage? There are very specific timelines to protect coverage while the appeal is occurring, 15 days from notice, and then 90 days for appeals. One of the primary reasons was the patient did not have a good address on record so the notice for required information was not received; or the patient did not have all the required financial information as Medicaid is an income based program.

With the magnitude of rejections – averaging 75% of all applicants being rejected nationwide for procedural issues – the financial, mental and emotional health of our patients is being severely impacted. The redetermination process required each state to do extensive outreach to prevent inappropriate denials. Unfortunately, the Kaiser Family Foundation 's survey in early summer found approximately. 65% of the Medicaid population did not realize this was happening.

The patient stories of care being discontinued – for children in ongoing treatment, appointments being canceled due to a lack of insurance, etc. - all are concerning.

What is the role of the Healthcare provider in assisting each patient in their overall understanding of what is occurring? How can the internal Patient Financial Navigators lead the hospital's and other healthcare providers in defining an outreach process to assist with finding coverage or filing an appeal, or try to prevent coverage gaps?

The potential increase in bad debt is significant. The action to reduce this while being proactive to reach out and prevent more procedural denials can be mitigated by a powerful internal, organized provider outreach effort. It will more than pay for itself!

When we think about the mission for our PFS team-
Mine was always:

- My patient did not ask to be sick
- My patient did not ask to have their life disrupted.
- My patient did not ask to have their insurance pay so little or nothing at all
- My patient is sick and scared.
- How can I help you navigate through the Business of Healthcare?

The Medicaid Redetermination process is one of the most significant public health challenges healthcare providers and community outreach is facing. We can help!

About the Author

Day Egusquiza is Founder and President of AR Systems, Inc. & Patient Financial Navigator Foundation, Inc. She brings over 40 years' experience in health care reimbursement, including 20 years in an Idaho hospital leading hospital revenue cycle operations, contracting, new program development, auditing and compliance implementation. Additionally, Ms Egusquiza is a nationally recognized speaker on continuous quality improvement (CQI), benchmarking, redesigning, reimbursement systems and implementing an operational focus of compliance- both in hospitals and practices. Day can be reached at Daylee1@mindspring.

The Benefits of Tight CIO/CFO Collaboration

Rich Temple

by Rich Temple

"Improving Operations Through CFO/CIO Collaboration" will be presented at the 47th Annual Institute, Thursday, September 28 at 3:10pm.

The essence of this presentation will be to emphasize the importance of having a tight and collaborative relationship between the hospital Chief Financial Officer (CFO) and the hospital Chief Information Officer (CIO). It will explore how the CFO and CIO can work together to collaborate on vital enterprise-wide Key Performance Indicators (KPIs) as well as help prioritize Information Technology (IT) spending patterns in light of the fiscal realities at the health system. In many cases, the KPIs that are used transcend traditional Finance-based KPIs insofar as many different metrics that impact finance are derived from clinical or operational metrics, due to programs such as the Merit-Based Incentive Payment System (MIPS), value-based care (e.g., tracking readmissions at a granular level) and other risk-based payment models.

Recognizing IT touches virtually everything in a healthcare setting, the CFO can be an effective partner in helping to allocate funds for IT programs that are absolutely essential to the well-being of the health system, but may not have a readily quantifiable return on investment. Investments in cybersecurity are one example of this.

The CIO/CFO relationship is a critical one for health systems' ongoing viability across many dimensions.

About the Author

Rich Temple is Vice President and Chief Information Officer at the Deborah Heart and Lung Center in Browns Mills, NJ. Over the course of Rich's career, he has been a CIO at the Saint Clare's Health System and at AristaCare Health Services. He also was a National Practice Director for the Strategic Healthcare Practice at Beacon Partners (now KPMG). Early in his career, Rich cut his teeth in the revenue cycle world by working for Health Management Systems in New York City and McKesson's division that ran outsourced business offices for hospitals and large physician practices. Rich can be reached at templer@deborah.org.

New Jersey Membership Statistics

NJ Chapter 1,033 members with 197 Certified members.
Breakdown of Certifications:

- 49% CRCR Revenue Cycle Representative
- 20% CHFP Healthcare Financial Professional
- 13% FHFMA Fellow of HFMA
- 9% CSBI Specialist Business Intelligence
- 5% CSAF Specialist Accounting and Finance
- 3% CSPPM Specialist Physician Practice Management
- 2% CSPR Specialist Payment & Reimbursement

•Who's Who in NJ Chapter Committees•

2023-2024 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	(609) 560-9619	9:00 AM	(667) 770-1469
Board Liaison: Lisa Weinstein – lisa.weinstein@bancroft.org	(856) 348-1190	Access Code 473803	
Communications / FOCUS			
Chair: James Robertson – jrobertson@greenbaumlaw.com	(973) 577-1784	First Thursday of each month	Conference Call (667) 770-1479
Board Liaison: Brian Herdman – bherdman@cbiz.com	(609) 918-0990 x131	8:00 AM Access Code: 868310	In-person Meetings by Notification
Education			
Chair: Lisa Weinstein – lisa.weinstein@bancroft.org	(856) 348-1190	Second Friday of the Month	Zoom Meeting
Co-Chair: Tara Bogart – tara.bgart@pmmconlne.com	(704) 618-1531	9:00 AM	(646) 876-9923
Board Liaison: Kim Keenoy – kim.keenoy@bofa.com	(732) 321-5935	Access Code: 89425417190	via Zoom
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: Alicia Caldwell – alicia.Caldell@bakertilly.com	(732) 687-3535	Third Wednesday of each month	Conference Call
Co-Chair: Mia Morse – mmorse@matheny.org	(908) 234-0011 x1380	8:00 AM	(872) 240-3212
Board Liaison: Alex Filipiak – Alexander.Filipiak@rwjbh.org	(732) 789-0072	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: Sandra Gubbine– Sandy.gubbine@gmail.com	(609) 247-4434	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	MS Teams meeting
Co-Chair: Ari Van Dine – Ari.VanDine@rsmus.com	(212) 372-1278	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 Financial Services and Patient Access Services			
Chair: Daniel Demetrops – ddemetrops@medixteam.com	(845) 608-4866	Second Friday of each month	Conference Call
Co-Chair: Marco Coello – mcoello@affiliatedhmg.com	(973) 390-0445	at 10:00AM	Call Line (667) 770-1453
Board Liaison: Amina Razanica – arazanica@njha.com	(609) 275-4029	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: Maria Facciponti – maria.facciponti@elitereceivables.com	(973) 583-5881	In person with call in available	Goldman offices
		via WebEx (Contact Committee)	90 Woodbridge Center Dr.. Woodbridge, NJ
Regulatory & Reimbursement			
Chair: James O'Connell – OConnellJ@ihn.org		Third Tuesday of each month	MS Teams Call
Co-Chair: Paul Croce – pcroce@greenbaumlaw.com	(973) 577-1806	9:00 AM Call Line: (732) 515-4266	
Board Liaison: Chris Czvornyek – chris@hospitalalliance.org	(609) 989-8200	Phone Conference ID: 670 733 396	
Revenue Integrity			
Chair: Tiffani Bouchard – tbouchard@panaceainc.com	(651) 272-0587	Second Wednesday of each month	Conference Call
Co-Chair: Jonathan Besler – jbesler@besler.com	(732) 392-8238	9:00 AM Access Code: 419677	
Board Liaison: Jonathan Besler – jbesler@besler.com	(732) 392-8238	Call Line (667) 770-1275	
CPE Designation			
Chair: Lew Bivona – lewcpa@gmail.com	(609) 254-8141		

Healthcare Hot Topics: You Literally Cannot Afford to Miss This

Jeny McNair

by Jeny McNair

"It's a shame you did all that training and can't even use it now!" After 11 years of medical school and residency and several years in clinical practice, I became a Physician Advisor. It was a great fit for my interest and lifestyle and I felt very fortunate. My sisters-in-law's mother, however, pitied me and my career 'loss'. I knew better.

In the nascence of the industry, the Physician Advisor's scope focused on assessing and correcting levels of care. As the field evolved, Physician Advisors did more: revenue cycle, quality, continuing education, etc. This scope creep became integral to the role of Physician Advisor (PA), and necessitates that PAs remain abreast of frequently changing regulatory directives while achieving operational efficiencies to impact the health of the hospital system. Physician Advisors straddle the crossroads of hospital departments impacting both compliance and revenue.

Early CMS rules mandated the establishment of UM committees and provided guidance to determine appropriate level of care. As the enrollment patterns in the industry have shifted towards Medicare Advantage, certain patterns have emerged. In 2022, the OIG raised concerns about Medicare Advantage gaming the system to maximize profits. As a result of this report as well as industry and individual complaints, CMS proposed and recently adopted Rule 4201, known as "Medicare Program Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program."

Over time, Medicare Advantage plans have enacted policies that may delay care or prevent it altogether, drawing the attention of the OIG.

What is a Medicare Advantage plan and how does it differ from traditional Medicare? As a young hospitalist, I neither understood nor cared. Now, having worked on the payer side, and caring for aging Boomer parents, I understand, and I care.

To sell Medicare Advantage (MA) product to consumers, payer organizations must offer AT LEAST the services traditionally covered by Medicare AND extra perks and services that would provide health value to consumers, i.e., dental coverage or vision coverage, or meals after discharge, etc. The payers expect to manage their enrollees with fewer expenditures, maximizing their profits.

Over time, Medicare Advantage plans have enacted policies that may delay care or prevent it altogether, drawing the attention of the OIG. These impacts to consumers prompted the creation of Rule 4201, which focuses on Medicare Advantage plans in the following areas:

Behavioral Health access to care

Star Ratings

Utilization Management and prior authorizations

Low-income subsidies

Marketing requirements

Health Equity

Perhaps the most controversial part of this final rule relates to utilization management. Providers have long-awaited a time when Medicare Advantage plans adhere to the same standards as traditional Medicare, i.e., the 2-midnight rule and the Inpatient Only list. Despite requests for CMS to include specific language in the final rule, its absence is notable. The rule outlines the use of NCDs and LCDs and allows payers to create guidelines in the absence of established criteria, if these guidelines are evidence based and if the criteria are available externally with sources. Anecdotally, payers have not admitted to any anticipated changes in adjudication of medical necessity. With an effective date of 1/1/24, providers and Physician Advisors remain on tenterhooks.

When they are not on tenterhooks, Physician Advisors continue in their traditional roles. One of which is execution of peer-to-peer discussions with payers.

Many payers offer the opportunity for a peer-to-peer discussion between the provider or Physician Advisor and the payer medical director if a case is denied for inpatient pre bill drop.

Facilities vary widely in their approach to these peer-to-peer opportunities with some facilities skipping it altogether and going straight to appeal. Other facilities may execute a portion of peer-to-peer opportunities but not all. Why is it important to take advantage of these peer-to-peer opportunities? One inpatient denial overturn per week for a year can increase payment propensity $700,000. Additionally, there's no predicting when an overturn might go the provider's way. When a facility doesn't execute all opportunities for peer-to-peer, they're in essence self-denying and pushing that claim to appeal or write-off. The ROI for peer to peers can be 16:1 or greater with a well-trained effective Physician Advisor.

Then, there's the other peer to peer - where nothing went right when it should have.

Egregious payer behavior is a tough nut to crack. In this Physician Advisors experience, egregious behavior falls into one of two categories. 1 - administrative and 2 - substantive.

Administrative egregious behavior includes behavior that reduces the likelihood of completing a peer to peer because of administrative burden or misdirection. For instance, a payer states peer to peer is available until 12 p.m.; when the payer is reached at 11:45, they state that 12 p.m. actually means the request must be received by 11 a.m. so they have time to call back. Now, at 11:45, the peer-to-peer window is closed.

Substantive egregious behavior includes cases that are truly and objectively inpatient, but the payer denies the inpatient stay for nebulous reasons. Example: patient with a severe COPD exacerbation on IV steroids for 5 days with new oxygen requirement, symptomatic but improving. Payer denies because "this patient is getting better, even if it took 5 days. That's observation." Um. No. That's a medical team doing their job well.

Ensuring accountability depends on a methodical, data-driven strategy. Ideally, you'll be supported by a team of data analysts using data aggregators. But here in the real world, at least, create a payer-specific log of these cases and keep it going! Use this data in every Joint Operating Committee meeting with the payer. Discuss each case, line by line. Establish a clear escalation pathway for these situations. Include the Lead Physician Advisor in the JOCs. Escalate, renegotiate, then escalate again!

One inpatient denial overturn per week for a year can increase payment propensity $700,000.

For new plans wanting to partner with the facility, include clinical representation for UR (ideally, the lead PA) in the contract negotiations. Items such as the definition of medical necessity, peer-to-peer windows and execution, reconsideration periods, etc., should be discussed and understood by both parties before formalizing an agreement with a new payer.

Healthcare is a tough industry. There's always more to consider, more to learn and more to negotiate. Regulatory updates, efficiency, quality…none of it is static. But it turns out I'm using my medical degree after all, Lynn – so no sympathy needed.

About the Author

Dr. McNair is a Hospitalist, Physician Advisor, artist, sailor, and dog-rescuer. She is the President and Chief Physician Advisor at Med-Metrix Physician Advisory. Dr. McNair attended the University of Texas Health Science Center in San Antonio and trained at Wake Forest Baptist Medical Center in North Carolina. She's passionate about data, operational efficiency, performance management, and mentoring. Dr. McNair can be reached at jmcnair@med-metrix.com.

New Members

Mariela Medina
Trinity Health
Patient Financial Customer Service
mariela.medina@trinity-health.org

Abigail Hernandez
Trinity Health
Customer Service Representative
abigail.hernandez001@trinity-health.org

Nate Alpern
Null
Senior Financial Analyst
nathan.alpern@tuhs.temple.edu

Jay Herman
New York University Wagner School Director, Finance
jdh420@nyu.edu

Chaim Sender, CSBI
chaim.sender@student.uagc.edu

Rebeccca Santoro
On Time Transport
Director of Finance
rsantoro1988@gmail.com

Christian Dominguez
Atlantic Health System Inc
Director of Accounting, Reporting
and Reimbursement
christian.dominguez@atlantichealth.org

Julius Isaac
Atlantic Health System Inc
Manager
julius.isaac@atlantichealth.org

Vikas Vats
SmartPBC
Cofounder vikas@smartpbc.net

Christine Ha
One Medical
Senior Financial Analyst
ha.christinee@gmail.com

Robert Tomiello, CRCR
Valley Health System NJ
Medicare RAC Analyst
bobt1119@optonline.net

Jeanmarie Falco
OrthoNJ
Executive Director
jfalco928@outlook.com

Kelly Lawson
klawson@bayada.com

Justin Karakkat
Oracle
Functional Testing Consultant
justin.karakkat@oracle.com

Nick DeRose
Legacy Treatment Services, Inc.
Chief Business Development Officer

Thomas Morabito
EY
Senior Director
thomasmorabito137@gmail.com

Gabriel Anthony
Huron Consulting Group
Director
gsanthony@hcg.com

Yash Gandhi
PwC
Senior Associate
yash.d.gandhi@pwc.com

Michael Kelly
Hackensack Meridian Health
Human Resources Manager
michael.kelly2@student.uagc.edu

Carolina Douglas
Atlanticare
Patient Access Associate
carolina.douglas@atlanticare.org

Diana Sanchez
Atlanticare
Fiancial Counselor
diana.sanchez@atlanticare.org

Vaishali Raval
Financial Counselor
vaishali.raval@atlanticare.org

Marcy Greenblatt
Senior Business Manager
mgreenblattcpa@gmail.com

Romeo Racraquin
Financial Assistant Representative 1
romeo.racraquin@atlanticare.org

Jacquelin Hayes
Unemployed
jhayes320@aol.com

Hannah Padron
hannah.padron@student.uagc.edu

Nadia Smith
Montefiore Health System
Learning and Development Manager
nadismith@montefiore.org

Misty Connelly
Rowan University
Practice Manager
mconnelly004@my.wilmu.edu

Leena Anklesaria
Temple University Hospital
Sr. Manager of Revenue Integrity
leena.anklesaria@tuhs.temple.edu

Nichole Meuse
UrgiMed Urgent Care
Director of Operations/Assistant Medical Director
nichole.meusellc@gmail.com

Vonceia Petteway
vonceia.petteway@student.uagc.edu

Rahul Dewale
Mount Sinai Health System
Administrative Compliance Coordinator
rahul.dewale9@gmail.com

Janell Carrasco
Nurse Manager
janell.carrasco@student.uagc.edu

Edith Ponce
edith.ponce@student.uagc.edu

Amanda Irving
Director
amanda.irving@consensushealth.com

Kristen Gallagher
Jefferson
Director Patient Access
kristen.gallagher@jefferson.edu

Jessica Brown
Atlanticare Regional Medical Center
Financial Counselor
jessica.brown@atlanticare.org

Janette Rapp
Atlanticare
Patient Access Associate
janette.rapp@atlanticare.org

Aidan Ziobro
Bergen New Bridge Medical Center
Assistant Director of Pharmacy
aziobro@newbridgehealth.org

Myrna Brignol
Jefferson Health System
Administrative Fellow
brignolmyrna@gmail.com

Karyn Pendleton
Penn Medicine
Financial Services Representative
karyn.pendleton@pennmedicine.upenn.edu

John Laporta
Princeton HealthCare System
Manager, Revenue AR Valuation
john.laporta@pennmedicine.upenn.edu

Jessica Williams
Penn Medicine
Manager, Accounting
jessica.williams@pennmedicine.upenn.edu

Michael Lovett
Consensus Health
Controller
michael.lovett@consensushealth.com

The Conclusion of the Public Health Emergencies: What This Means for Healthcare Providers and The Accommodations That Had Been Put in Place by the Federal and State Governments

John Kaveney

by John W. Kaveney

At the beginning of the COVID-19 public health emergencies ("PHEs"), the federal government and state governments across the country used emergency waiver authorities and various regulatory authorities to enable flexibilities so providers could rapidly respond to people impacted by COVID-19 while also ensuring the public could continue to access necessary healthcare in a safe and effective manner. Moreover, action was taken to ease the financial pressures on hospitals and other healthcare providers impacted by the influx of COVID-19 patients and the temporary cessation of other services. With the PHEs concluding both federally and here in New Jersey, some of these temporary accommodations are being extended while others are either expiring shortly or have already expired. Providers must be prepared to make the appropriate adjustments as we shift into a post-PHE world.

Several key areas must be closely watched given the legal landscape is evolving quickly as the federal government and New Jersey's state government assess what a post-PHE world should look like when delivering healthcare. Areas impacted include telehealth services, including privacy and security enforcement; relaxation of provider licensure requirements; coverage for COVID-19 treatment, testing, and prevention; enhanced financial support by the federal government and New Jersey; and other accommodations. The following is a summary of some of these key impacted areas of the industry.

Extensions of Telehealth Flexibilities Via the Consolidated Appropriations Act

One of the most notable legislative acts to extend many of the telehealth flexibilities came with the passage of the Consolidated Appropriations Act ("CAA") of 2023.[1] The CAA extended many of the pandemic-era telehealth flexibilities including, but not limited to, the following items:

- ***Telehealth services provided at home will continue to be covered by Medicare –*** The *originating site* has historically served as a significant restriction to where a patient could receive telehealth services. During the pandemic this definition was relaxed to include locations such as a patient's home or temporary residence and to eliminate the exclusivity of patient's being located only in rural areas. The CAA extended this relaxed definition through December 31, 2024, with it being made permanent for behavioral health services.

continued on page 20

continued from page 19

- ***Audio-only telehealth will continue to be covered by Medicare –*** Post-PHE behavioral and mental audio-only telehealth services will be permanently covered by Medicare while certain non-behavioral telehealth services offered via audio-only will continue to be covered through December 31, 2024.
- ***Continued expanded list of qualified telehealth providers –*** The list of providers eligible to continue offering telehealth services to Medicare beneficiaries will remain expanded to include physical therapists, occupational therapists, speech language pathologists, and audiologists. Prior to the PHE, only physicians, nurse practitioners, physician assistants and other specified providers were covered. This expanded list of telehealth providers will remain in effect until December 31, 2024.
- ***Continued utilization of at-home acute hospital care through telehealth –*** Under the CAA, the acute hospital care at home program was extended to allow the continued utilization of acute care hospital services to patients in their homes, including through telehealth. Similar to other extensions, Medicare beneficiaries will be able to permanently receive behavioral health services at home, whereas for non-behavioral health services, it has been extended through December 31, 2024.
- ***Delaying of the in-person requirement for telehealth mental health services –*** A relatively new Centers for Medicare and Medicaid Services ("CMS") rule requires an in-person visit within six months of the first behavioral/mental telehealth service provided to a patient and an in-person visit at least every twelve months thereafter to qualify for Medicare coverage. This requirement has been delayed by the CAA and will not go into effect until after December 31, 2024. Many in the behavioral health space have questioned the need for this in-person visit and thus it remains to be seen if further changes will be made to the law.

"With the PHEs concluding both federally and here in New Jersey, some of these temporary accommodations are being extended while others are either expiring shortly or have already expired. Providers must be prepared to make the appropriate adjustments as we shift into a post-PHE world."

Expiration of the Office of Civil Rights' Enforcement Discretions

The U.S. Department of Health and Human Services Office for Civil Rights ("OCR") exercised its enforcement discretion during the PHE to relax various requirements of the Health Insurance Portability and Accountability Act ("HIPAA") rules.[2] This enforcement discretion was only to remain in effect during the pendency of the PHE to allow greater flexibility so that providers could creatively ensure healthcare delivery to patients while not fearing penalties from the government for certain failures to demonstrate absolute compliance with HIPAA.

In the months leading up to the expiration of the PHE, OCR announced that these enforcement discretions would expire, and HIPAA enforcement would return to its pre-pandemic standards post-PHE. However, prior to the May 11, 2023 expiration of the PHE, OCR announced it had decided to provide for a 90-calendar day transition period for covered healthcare providers to come back into compliance with the HIPAA rules with respect to the provision of telehealth. Thus, providers were given until August 9, 2023, at 11:59 p.m. before penalties would again begin to be imposed for certain aspects of HIPAA.

Services Continued to be Included On the Medicare Telehealth Services List

In an effort to continue to reduce exposure risks, through the conclusion of 2023, CMS has decided to maintain its expanded list of services permitted to be provided via telehealth, and thereby covered by Medicare. CMS anticipates addressing whether to continue to include the items on this expanded list into 2024 and beyond through its established processes as part of the CY 2024 Physician Fee Schedule proposed and final rules.[3]

Prescribing of Controlled Substances Via Telehealth

The ability of providers to prescribe certain controlled substances via telemedicine was also at risk of significant change upon the expiration of the PHE. During the course of the PHE, providers were permitted to prescribe controlled substances via telemedicine without the need for in-person examinations of the patients. However, with the expiration of the PHE, and pursuant to a pending new rule published in February 2023 by the federal Drug Enforcement Administration ("DEA"), in-person examinations would again be a requirement to ensure continuity of care. Under the proposed DEA rule, if a patient had not been seen in-person, and was in need of a controlled medication, providers would be limited to prescribing a 30-day supply of Schedule III-V non-narcotic controlled medications, or a 30-day supply of buprenorphine for the treatment of opioid use disorder without an in-person evaluation or referral from a physician that conducted an in-person evaluation. For Schedule II medications or Schedule III-V narcotic-controlled

medications, an initial in-person exam would again be required before any such prescriptions.[4]

Despite this proposed rule remaining under review, the DEA subsequently published a statement advising that, "[w]e recognize the importance of telemedicine in providing Americans with access to needed medications, and we have decided to extend the current flexibilities for six months while we work to find a way forward to give Americans that access with appropriate safeguards."[5] Thus, the industry is awaiting further guidance from the DEA regarding what it will do with its pending proposed rule and whether it will reverse course on its current proposal to require in-person evaluations.

Virtual Direct Supervision Set to Expire

Another key PHE waiver was the permission by CMS for providers to utilize remote, real-time, interactive audio-video technology to satisfy Medicare Part B's direct supervision rules for certain types of services. Historically, Medicare has required a supervising professional to be physically present in the same office suite and "immediately available" to furnish assistance and direction for it to qualify as "direct supervision" and thus be covered by Medicare. In CMS' 2023 Medicare Physician Fee Schedule final rule,[6] CMS declined to extend the utilization of virtual direct supervision. As a result, it is set to expire at the end of 2023.

Parity of Medicare Payments for Telehealth

Another area of change for providers is the parity in Medicare payments that providers were receiving during the pandemic despite providing services via telehealth instead of in-person. For services rendered via telehealth at non-facilities (i.e. at a patient's home), CMS has been reimbursing the telehealth services at the same rate as a regular, in-person visit. These higher reimbursement rates for telehealth services are scheduled to expire at the end of the year. It remains to be seen whether lawmakers or CMS will attempt to change this policy and either extend or make permanent the greater reimbursement rates.[7]

Parity of Payments in New Jersey for Telehealth

At the outset of the PHE, New Jersey mandated that health benefit plans similarly reimburse providers for telehealth services at the same rate as in-person services, with limited exceptions. In December 2021, New Jersey enacted a law extending this requirement for a two-year period.[8] Thus, through the end of 2023, New Jersey health benefit plans, Medicaid and NJ FamilyCare, and the State Health Benefits Program (SHBP) and School Employees' Health Benefits Program (SEHBP) must reimburse providers at the same rate as those rendering care in-person.

In 2020, the New Jersey Legislature passed a different bill stating that during the PHE and state of emergency declared by the Governor in Executive Order 103, the State Medicaid and NJ FamilyCare programs shall provide coverage and payments for expenses incurred in the delivery of healthcare services through telemedicine or telehealth in accordance with the provisions of P.L.2017, c.117.[9] While the New Jersey PHE has expired, the state of emergency has continued to remain in place ever since.[10] Consequently, Medicaid and NJ FamilyCare continue to be a source of comparable reimbursement and payment for telehealth services in New Jersey.

New Jersey Utilization of Out-Of-State Practitioners

In 2020, New Jersey acted to allow out-of-state practitioners to treat residents of New Jersey both in-person and via telehealth. While those relaxations of the licensure rules were originally set to expire with the conclusion of the New Jersey PHE, some exceptions were put in place to allow the continued utilization of out-of-state practitioners. The New Jersey Division of Consumer Affairs generally eliminated the Temporary Emergency Reciprocity Licensure Program. However, an exception was made for respiratory therapists, which has since expired, and Senate Bill 4139 extended the temporary authorization for "Group 2 health care professionals" until 60-days after the conclusion of the federal PHE, or until July 10, 2023. Thus, providers must move away from the utilization of out-of-state practitioners not appropriately licensed to practice medicine in the State of New Jersey.[11]

Coverage for COVID-19 Treatment, Testing, and Prevention

During the PHE, individuals did not have to think about access to, and paying for, COVID-19 vaccinations, tests, and treatments. Significant efforts were made to ensure these critical items were available to those in need, in most cases without any cost to the patient. However, with the PHEs having expired, and government supplies of vaccinations and tests running out, decisions are actively being made to determine if and how these items will be made available going forward.

For vaccinations, the New Jersey Department of Health has indicated that, in coordination with the Centers for Disease Control and Prevention ("CDC") and the Department of Health and Human Services ("HHS"), they will continue to work to ensure the public, especially high-risk populations, are able to access COVID-19 vaccinations. For Medicare and Medicaid, there will continue to be coverage for the costs without co-pays or cost-sharing, even when the government supply runs out. Until government supplies run out, private insurance will similarly cover vaccines and boosters, but have exceptions for out-of-network providers or grandfathered plans when government supplies run out. Those who are underinsured/uninsured

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will continue to be able to get a COVID-19 vaccine for free from any provider participating in the CDC COVID-19 Vaccination Program.[12]

With regard to treatments, patients will likely face more traditional cost-sharing obligations. For Medicare beneficiaries, they may face cost-sharing for certain COVID drug treatments such as monoclonal antibody treatment and medicine, Lagevrio and Paxlovid. For Medicaid and CHIP programs, they will continue to cover all drug treatments with no-cost sharing through September 2024, but thereafter states may place limits on how much can be distributed along with minimal cost-sharing. For private insurance, there will be continued coverage, but there is likely to be cost-sharing or copays for all medicine and treatments related to COVID-19. Finally, for underinsured/uninsured, they may need to pay full price for treatments and medicine once the federal supply runs out.[13]

Finally, for COVID-19 testing, much of the freely available tests will no longer be available once current government supplies run out. For Medicare, recipients will have coverage for provider-ordered lab tests but may have a cost-sharing responsibility for testing-related services. Coverage for at-home testing will no longer be provided. For Medicaid programs, coverage of all costs will continue until September 30, 2024, after which time coverage may vary by state. At home testing and provider-ordered lab testing will not be covered for private insurance unless the private insurer decides to maintain coverage for testing going forward. And, uninsured/underinsured individuals, once the federal supply runs out, will not have access to free at-home tests, and have limited sites where it can go for free COVID-19 testing.[14]

Thus, COVID-19 vaccinations, treatments, and testing are set to become like most other medical vaccinations, treatments, and tests in terms of coverage and cost-sharing obligations for patients.

While the above discussion outlines several of the key flexibilities and waivers of the pandemic that are either continuing beyond the PHE, or which expired with the conclusion of the PHE, there are still many other flexibilities and waivers, both on a federal level and in New Jersey, that could be discussed herein, and which will impact providers across the State of New Jersey. Providers must be vigilant to ensure they remain updated on any new changes that occur, especially since this is a dynamic area of the law that is changing by the day. Thus, it is safe to assume the current status of these flexibilities and waivers will continue to evolve as we move further from the PHE, and federal/state legislatures, agencies, and insurance companies evaluate the future of healthcare.

About the Author

John W. Kaveney, Esq. is a Partner in the Healthcare and Litigation Departments at Greenbaum, Rowe, Smith & Davis LLP, where he concentrates his legal practice on corporate compliance matters, information privacy and data security, and Medicare reimbursement matters, as well as general regulatory guidance and healthcare litigation. He can by email at jkaveney@greenbaumlaw.com.

FOOTNOTES

[1]H.R. 2617 - https://www.congress.gov/117/bills/hr2617/BILLS-117hr2617enr.pdf

[2]https://public-inspection.federalregister.gov/2023-07824.pdf https://www.hhs.gov/about/news/2023/04/11/hhs-office-for-civil-rights-announces-expiration-covid-19-public-health-emergency-hipaa-notifications-enforcement-discretion.html

[3]https://www.cms.gov/files/document/physicians-and-other-clinicians-cms-flexibilities-fight-covid-19.pdf

[4]https://www.dea.gov/press-releases/2023/02/24/dea-announces-proposed-rules-permanent-telemedicine-flexibilities

[5]https://www.dea.gov/documents/2023/2023-05/2023-05-03/statement-dea-administrator-anne-milgram-covid-19-telemedicine

[6]https://public-inspection.federalregister.gov/2022-23873.pdf

[7]https://www.govinfo.gov/content/pkg/FR-2020-04-06/pdf/2020-06990.pdf

[8]https://www.njleg.state.nj.us/bill-search/2020/S2559

[9]https://pub.njleg.gov/bills/2020/PL20/7_.PDF

[10]https://nj.gov/infobank/eo/056murphy/pdf/EO-244.pdf

[11]https://pub.njleg.gov/Bills/2020/S4500/4139_I1.HTM

[12]https://www.state.nj.us/health/cd/documents/topics/NCOV/Public_FAQ.pdf

[13]Ibid.

[14]Ibid.

Adapting to New Medicare Cost Reporting Requirements Under Transmittal 18

Fred Fisher

Scott Besler

by Fred Fisher and Scott Besler

On December 29, 2022, CMS finalized updated Medicare cost report instructions under Transmittal 18 (T18) with significant reporting changes. Transmittal 18 is generally effective for cost reporting periods beginning on or after October 1, 2022 (e.g., FYE December 31, 2023), unless otherwise noted by CMS. This article breaks down notable areas of the T18 updates.

Uncompensated Care (UC) DSH

Acute Care Only UC Costs (UCC)

DSH providers currently report and are reimbursed based on UCC related to the entire "hospital complex" on Worksheet (WS) S-10. T18 instructions now require DSH providers to report UCC for acute care services only on WS S-10, Part II. UCC from the entire hospital complex will still be reported and used for reimbursement. However, down the road, CMS may propose to reimburse hospitals based on acute care only UC costs. The Office of Management and Budget (OMB) notes in its responses to CMS cost report changes that:

> "WS S-10, Part II data will be collected so that CMS may consider the general short-term hospital inpatient and outpatient detailed information, in future years, in determining the scope of the UCC data for purposes of the uncompensated care payment methodology."

Toyon conducted an analysis estimating providers with more than 16% of subacute population (using days as a proxy) would experience a decrease in UC DSH payments under an "acute care" only method of allocating UC DSH reimbursement.

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Updated Definitions and Clarifications

T18 includes clarifications on categories of allowable vs. non-allowable UCC. These clarifications cover non-medically necessary UCC (not allowable), non-covered charges (allowable) vs. denied charges (not allowable), inferred contractual charges (allowable), and contractual allowances (not allowable). T18 also includes clarifications that charity care is per a hospital's written financial assistance policy. Toyon recommends DSH providers evaluate their financial assistance policies to determine if they address and cover all allowable forms of UCC per T18.

New Exhibits for Charity Care and Bad Debt Support

DSH providers are required to submit detailed patient logs for their charity care and bad debt reported as UCC on WS S-10. In T18, CMS provides hospital teams new templates and instructions for reporting the required fields of data to support write-offs for charity care (Exhibit 3B) and bad debt (Exhibit 3C). CMS is also now requiring providers to file separate exhibits for each Medicare provider that is a part of the respective hospital (e.g., acute care, rehabilitation, psychiatric care, etc.).

The exhibits in T18 include several new fields, such as non-allowable charity care amounts (e.g., write-offs that are not

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specified in a provider's financial assistance policy). It is key DSH providers evaluate their patient accounting systems to determine the ability to populate each of the fields required in the charity care and bad debt listings. Providers should also ensure the listings are prepared so that Medicare auditors can reconcile an account's charity care and bad debt write-offs, as well as the outstanding account balance.

Empirical DSH

Prior to T18, DSH providers did not have a standard template to report Medicaid-eligible days used in the determination of a hospital's Medicare DSH factor. T18 finalizes the required fields DSH hospitals must use to report their Medicaid-eligible days in Exhibit 3A. This exhibit includes 18 columns, and a separate exhibit is required for each Medicare provider (e.g., acute care, rehabilitation, psychiatric care, etc.). Notably, CMS clarifies that Medicaid-eligible newborn days (column 12) are reported separate from their mother's Medicaid-eligible days (column 10), except when the newborn Medicaid-eligible days occur after the mother's discharge date. This is illustrated in the example below:

Mother – Admitted on 6/1/2023 and discharged on 6/3/2023. Two days are reported in column 10.

Newborn – Admitted on 6/1/2023 and discharged on 6/7/2023. This newborn stay will be reported on two separate lines.

- The first three days are reported in column 12 (6/1, 6/2, 6/3).
- The three days that occurred after the mother's discharge date are reported in column 10 (6/4, 6/5, 6/6) on a separate line.

Both lines will use the same patient account number in column 5 of Exhibit 3A.

The issuance of Exhibit 3A does not impact or change the structure of the DSH payment. The expectation is that DSH hospitals will report and file their DSH patient listing in a standard format, allowing the MACs to better standardize their review process. DSH hospitals will also continue to report their Medicaid DSH days under the six different columns on WS S-2, Part I, line 24 or 25.

Medicare Bad Debt

T18 finalizes the required fields providers must file to support Medicare bad debt deductible and co-pay (D&C) amounts. The new exhibit (Exhibit 2A) includes 24 fields whereas the previous exhibit (Exhibit 2) included 10 fields of data. Separate exhibits are required for each Medicare provider (e.g., acute care, rehabilitation, psychiatric care, etc.) and split between inpatient and outpatient services. Exhibit 2A of T18 includes the recording of multiple dates supporting the write-off amount, these dates include:

- Medicare remittance advice (R/A) date (column 9)
- Medicaid R/A date (column 10)
  - Providers may enter "AD" in column 10 if alternate documentation (other than a Medicaid R/A) was used to determine the state liability for a Medicare/Medicaid dual-eligible patient.
- Secondary payer RA received date (column 11)
- First bill sent to beneficiary date (column 13). Listed below are some recommendations related to this column:
  - Report blank if the patient was not billed.
  - If the beneficiary is a Quality Medicare Beneficiary (QMB), enter "QMB".
  - The date of the first bill must be issued within 120 days of the latter:
    - Date of Medicare R/A that results from processing the claim for services furnished to the beneficiary and generates the beneficiary's cost-sharing amounts.
    - Date of the R/A from the beneficiary's secondary payer, if any.
    - Date of notification that the beneficiary's secondary payer does not cover the service furnished to the beneficiary.
- Accounts receivable write-off date (column 14)
- Return from collection date (column 15)
- Collection effort ceased date (column 16)
- Medicare write-off date (column 17)
  - This date should represent when D&C were written off as a Medicare bad debt (written off as bad debt against the A/R); all collection efforts ceased; and a Medicaid remittance advice was received from the state for Medicaid patients.
- Recovery of payment FYE date (column 19, optional)
  - This column relates to any recovery or payment received for a patient balance that was already written off on a prior cost report.

T18's issuance of Exhibit 2A does not impact or change the policies and guidelines that hospitals must follow in order to compliantly claim Medicare Bad Debt under 42 CFR 413.89. The expectation is all hospitals will report and file their Medicare Bad Debt patient listings in a standard format.

Other Notable T18 Changes

Other notable changes and clarifications in Transmittal 18 include, but are not limited to, the following:

- Graduate Medical Education – New cost report lines and instructions related to:
  - Revised direct graduate medical education (DGME) weighted FTE count. This change results from the Hershey v. Becerra ruling whereby a provider's DGME FTE count cannot be less than the cap. Teaching providers should ensure that any corrections to their weighted DGME FTE count also account for the change to the prior and penultimate year (as the CMS payment formula is based on a three-year average of the current, prior and penultimate year FTE count). Impacted teaching providers should ensure this change is applied to all open cost reports (cost reports that have not yet received a N tice of Program Reimbursement, NPR).
  - New or revised resident slots resulting from sections 126, 127 and 131 of the Consolidated Appropriations Act, 2021.
  - Reduction of bed counts (used to determine indirect medical education – IME – reimbursement) by "the number of temporary expansion COVID-19 PHE acute care bed days".
- Organ Acquisition costs – T18 includes new WS D-6 to determine Medicare's share of allogeneic stem cell acquisition cost effective for cost reports beginning on or after 10/1/2020. T18 also includes new subscripted lines related to revenue for organs sold and organ transplants to further identify transplants for Medicare beneficiaries, kidneys transplanted into Medicare Advantage beneficiaries, Medicare Secondary Payer (MSP) organs, and all other payer transplants.
- Purchased Services – Notation of purchasing greater than fifty percent of professional services from an unrelated organization located outside the main hospital's local area labor market. This information may be used in the evaluation future year Medicare reimbursement. The OMB notes in its response to the cost report changes that "*the requested information ultimately impacts the labor-related share of the wage index for IPPS hospitals, as well as the labor-related share for inpatient rehabilitation facility, inpatient psychiatric facility, and long-term care hospitals.*"
- New WS A expense lines for CAR T-cells (line 78) and Medicare-enrolled opioid treatment program (line 102).
- Clarification of Non-Chargeable Drugs Charged to Patients (WS A Line 73).
- Sequestration calculation in the cost report settlement schedules.
- Information collection for the Community Health Access and Rural Transformation (CHART) model.
- Renal Dialysis costs for pediatrics and Maintenance Acute Kidney Injury (AKI, WS I series).
- End Stage Renal Disease (ESRD) payment information (WS I-5 Part III).
- Extension of the relaxed low volume adjustment requirements and Medicare Dependent Hospital (MDH) status through December 23, 2024, in accordance with sections 4101 and 4102 of the Consolidated Appropriates Act, 2023.
- Recording of permanent adjustments to the TEFRA target amount per discharge.
- MAC Outlier Reconciliation at Tentative Settlement (WS E-5).

About the Authors

Fred Fisher is VP Service Development at Toyon Associates and can be reached at fred.fisher@toyonassociates.com.

Scott Besler is Senior Director and can be reached at scott.besler@toyonassociates.com.

•Focus on Finance•

Federal Tax Credit Incentives for Clean Energy Capital Expenditures

By Lynn Mucenski-Keck, Principal

Lynn Mucenski-Keck

Significant changes in the Inflation Reduction Act of 2022 ("IRA") allow not-for-profit hospitals to receive an IRS refund or monetize accelerated deductions with engineers and architects for certain clean energy improvements, even if no tax liability is due.

While in previous taxable years, not-for-profits were limited to capturing these cash benefits only if they had unrelated business income tax ("UBIT"), under the IRA, all not-for-profits are incentivized to invest in clean energy infrastructure through the direct payment program regardless of tax liability. The newly created direct payment option under Internal Revenue Code §6417 generally allows tax-exempt entities to receive a cash tax refund for applicable credits, including credits related to the purchase of qualified commercial vehicles, charging stations, and energy projects. In addition, the IRA allows tax-exempt entities the opportunity to provide an immediate deduction related to energy-efficient commercial buildings to the person primarily responsible for designing the building improvements, thereby assisting in price negotiation. Key areas for not-for-profits to evaluate before planning future capital improvements are below.

Q. How can we evaluate energy independence?

A. Many hospitals find energy costs too erratic and struggle to budget properly for the significant swings. Some have chosen to explore alternative energy production, including solar energy production, combined heat and power systems, and energy storage technology. Under the IRA, a credit of up to 50% of the costs can be received for energy projects placed in service before January 1, 2025. Ten percent of the credit is provided if the energy project is in an energy community, including Brownfield sites. Another 10% is provided for the utilization of at least 40% of steel, iron, or manufactured products produced in the United States.

The property's basis generally includes the tangible property's cost and the capitalizable costs such as sales tax, freight, engineering, and installation. However, certain building structures can sometimes be included if they are an integral part of the energy project.

Example: Assume a hospital placed a large commercial solar panel that would generate 250kW's of electricity in the 2023 taxable year. The cost is estimated to be $750,000. Provided that the total expenses are deemed eligible costs for the energy credit, the hospital could generate a federal tax credit of $225,000, or 30%, even if it was not located in an energy community or did not meet the domestic steel and iron content requirements. If both the energy community and domestic content requirements are met, the federal tax credit could be as high as $375,000 (750,000 x 50%).

Not-for-profit entities could claim the credit on their 2023 tax return and request a refund. For-profit hospitals could either apply the federal tax credit against their 2023 tax liability or sell their federal tax credit to an interested party.

Q. Can commercial vehicles qualify?

A. A new federal tax credit is provided upon purchasing qualified commercial vehicles between 2023 and 2032. Qualified commercial vehicles must be propelled to a significant extent by an electric motor that draws electricity from a battery, including certain hybrid or electric vehicles. Qualified commercial vehicles could include general transport vehicles or more highly equipped medical vehicles such as ambulances or mobile medical vans. The maximum credit per vehicle with a gross vehicle weight of less than 14,000 pounds is $7,500 but is increased to $40,000 if the gross vehicle weight is 14,000 pounds or more. The overall credit can be limited based on the incremental costs of the qualified commercial vehicle compared to gasoline or diesel-powered vehicles.

Example: Assume an electric ambulance costs $400,000 per vehicle and the ambulance weighs more than 14,000 pounds. In addition, a similar ambulance that is gasoline-powered costs $325,000. The maximum federal tax credit allowed for this purchase would be $40,000. The maximum credit can be reduced if the incremental cost of the clean vehicle purchase, $75,000 (400,000-325,000) in our example, was less than the credit. In this example, no ad-

ditional credit limitation would occur. The purchase of the electric vehicle offset by the federal income tax credit, coupled with lower maintenance and gas costs, may incentivize hospitals to increase their investment in clean commercial vehicles.

Not-for-profit entities could claim the credit on the tax return the vehicle was placed in service and request a refund. For-profit hospitals could apply the federal tax credit against their 2023 tax liability. However, for-profit hospitals do not have the ability to sell commercial vehicle credits.

Q. How do charging stations fit into the mix?

A. With an increase in clean vehicles, there will also be a higher demand for charging stations. Under the IRA, the federal income tax credit was modified to provide up to 30% of the costs of a qualified alternative fuel vehicle refueling station for property placed in service before December 31, 2032. The modified credit provides a maximum credit of $100,000 per refueling station and is no longer assessed on the entire project.

To qualify as an alternative fuel vehicle refueling station, the property must be new and be for the storage or dispensing of clean-burning fuel, including electricity. In addition, the property must be placed in a low-income community or a non-urban area.

Example: Assume a hospital is interested in adding five additional level three charging stations, and they are deemed qualified alternative fuel vehicle refueling property. The charging station's purchase price, including installation costs, is $120,000 each. The federal tax credit could be as high as $180,000 ($120,000 x 30% x 5). The limitation of $100,000 is not applicable as no one charging station exceeded $100,000.

Not-for-profit hospitals would report the $180,000 credit when filing their tax return for the year the charging station was placed in service and request a refund. For-profit hospitals could either apply the federal tax credit against their tax liability or sell their federal tax credit to an interested party.

Q. How does this relate to the modernization of commercial buildings?

A. While many hospitals have explored becoming more energy efficient, often the up-front expense of energy upgrades compared to the savings incurred over the years results in a cash outlay that is not always feasible. Under the IRA, if the energy-efficient building improvements at a not-for-profit hospital reduce the total annual energy and power costs with respect to the interior lighting systems, heating, cooling, ventilation, and hot water systems of the building by 25 percent or more, a deduction can be transferred to the primary designer, and potentially assist with price negotiation. Alternatively, if a for-profit taxpayer engages in energy-efficient improvements, they can immediately deduct the capital improvements as opposed to depreciating the expense over 39 years.

Energy-efficient building improvements could include the installation of interior lighting, HVAC systems, water systems, and adjustments to the building envelope (i.e., windows and doors). The amount of the federal tax deduction allowed varies based on how much the building efficiency is increased. For example, assume the plan designed was able to reduce the hospital's total annual energy and power costs by more than 50%. Such a significant increase would create a maximum deduction based on $5 per square foot of the building where the improvements were placed. If the energy-efficient commercial building property could only certify that the plan designed reduced the total annual energy and power costs of the building by 25%, a maximum deduction of $2.50 per square foot could be obtained.

Example: Assume a hospital expends $1,250,000 on energy-efficient commercial building property installed in the 2023 taxable year. The square footage of the building is 300,000, and it was certified that the total energy costs were reduced by 50% due to these improvements. Based on the IRA, the maximum dollar amount per square foot would be $5. Therefore, assume the maximum deduction allowed for this space is $1,500,000 (300,000 square feet x $5). As the energy efficiency improvements were less than $1,500,000, the full amount of $1,250,000 of expenditures can be immediately expensed and deducted for tax purposes. Alternatively, if the building efficiency was only increased by 25%, the maximum deduction would be limited to $750,000 (300,000 square feet x $2.50).

If the improvements were made at a not-for-profit hospital, the hospital would be allowed to transfer the deduction to the primary designer. Assuming the engineer or architect has a federal effective tax rate of 20%, the cash benefit the designer could receive for the transferred tax deduction is $250,000 (20% x 1,250,000). The hospital would request that this benefit be monetized and reduce the ultimate fee that the hospital would have to pay the designer.

If the improvements were made to a for-profit hospital, the IRA now allows the full $1,250,000 of capital improvements to be immediately deducted instead of depreciating over 39 years.

While the overall construct was provided in the above examples, the IRA applicable dates, definitions, and requirements vary based on the property being placed in service and the type of credit that will be claimed. It can become overwhelming quickly. Withum is here to help hospitals throughout the entire process, from the planning stages to the recoupment of refund amounts, to ensure that the most beneficial credits are obtained and the proper documentation is provided.

About the Author

Lynn Mucenski-Keck, CPA, MST is Principal, National Lead, Federal Tax Policy, at Withum. She can be reached at lmucenskikeck@withum.com

The Prohibition on the Corporate Practice of Medicine is Alive and Well in New Jersey

James Robertson

by James A. Robertson

Generally speaking, licensed physicians in New Jersey cannot practice medicine in just any corporate form. But for a limited number of exceptions listed in N.J.A.C. 13:35-6.16, a physician may not be employed by a general business corporation to provide healthcare services. This is known as the prohibition against the corporate practice of medicine, or as we healthcare lawyers affectionately call it, "CPOM."

The reason for the CPOM doctrine is that an inherent conflict exists between a physician's obligation to provide medical care to his or her patient and the general business corporation's motive to maximize profits. The goal of CPOM is to remove the burden on physicians of choosing between providing appropriate medical care to their patients and being influenced by shareholders who are laypersons. The New Jersey Board of Medical Examiners ("BME") has safeguarded the CPOM rule because physicians alone are licensed to practice medicine and must be able to do so freely and without outside influence.

With this background, there are several ways physicians may structure their practices:

- ***As a solo medical practice*** with other employed professionals, including other physicians. It is important to note that in this structure, the physician, as the plenary licensed professional, must employ and supervise the limited licensed professionals such as nurses or physician assistants. It is inappropriate for any limited licensed professionals to hire or supervise a plenary licensed physician.
- ***As a partnership, professional association, or limited liability company,*** so long as the practice entity is composed solely of health care professionals who are licensed or authorized to provide the same or closely allied professional services (e.g., chiropractic, dentistry, nursing, nurse midwifery, optometry, physical therapy, podiatry, psychology, and social work). Oftentimes, a plenary license physician wants to form a partnership with a limited licensed practitioner, such as a chiropractor or nurse. This is not strictly prohibited but the physician must, at a minimum, maintain a greater ownership interest in the entity than the limited licensed partner. This is true whether the physician is in partnership with one or several limited licensed professionals – i.e., the physician must always maintain at least a 51% interest in the entity.
- ***Through an associational relationship*** (e.g., as an employee or independent contractor) with another physician or professional entity; however, it is important to remember that the physician's license may not exceed the scope of the hiring practitioner's license.
- ***In certain circumstances, a physician may have an equity or employment interest in a professional practice which is a limited partner in a general business corporation which has a contractual relationship with a professional service entity.*** In this model, the general business corporation may contract to provide administrative services, such as management services, hiring of non-professional staff, provision of office space and equipment, and billing services. The physician must ensure that an appropriate

The New Jersey Board of Medical Examiners ("BME") has safeguarded the CPOM rule because physicians alone are licensed to practice medicine and must be able to do so freely and without outside influence.

licensed health care professional determines and implements all medical services and policies, including decisions regarding patient fees and waiver of those fees in an individual case. The physician must also ensure that the general business corporation makes no representations to the public, under its own corporate name, about offering health services which require licensure.

In the case entitled *Allstate Insurance Company v. Northfield Medical Center, P.C.,*[1] the New Jersey Supreme Court issued its most recent pronouncement on the CPOM doctrine. Suffice it to say, the CPOM doctrine is alive and well. This case provides important guidance to providers attempting to comply with the strictures of the CPOM doctrine:

- A plenary licensed physician and a limited licensed (allied) health care professional cannot together own a medical practice that results in its control and direction by the limited licensed health care professional. In addition, an unlicensed individual cannot own a medical practice with a licensed health care professional.
- A general business corporation cannot employ or otherwise engage, for example, through an independent contractor relationship, a health care professional.

In light of the Supreme Court's ruling, it is more important than ever to structure the management services organization ("MSO") model between a management company, on the one hand, and a physician or medical practice, on the other, carefully to stay within the parameters of the CPOM rules. Special attention needs to be paid to the terms of the management services contract and the manner in which it is implemented and operationalized. In particular, one must resist the urge to

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Do's:	**Don'ts:**
Allocate the majority of shares and/or voting rights in the medical practice to the plenary licensed physician-owner(s)	Allocate more than a minority of shares or voting rights to any limited licensed professionals and never to an unlicensed individual
Require the physician-owner(s) to contribute start-up capital to the medical practice	The management contract should not contain a provision allowing the termination and replacement of the physician-owner in the event of a conflict of interest between proper medical judgment and cost-containment
Clearly delineate the roles between the physician-owner's clinical activities and the management company's administrative activities	Pay all remaining medical practice profits after expenses to the management company in exchange for the provision of management services, leased space, and leased equipment
Physician-owner(s) should participate in or oversee day-to-day patient care and supervision of clinical personnel	Require the physician-owner of the medical practice to presign undated documents or certificates which permit physician's removal from the practice
Physician-owner(s) should retain the right to terminate the management contract	Incorporate a "break fee" in the management agreement, space rental, or equipment leases which is intended to penalize the medical practice's physician-owner for breaking the management agreement or leases
The medical practice must pay fair market value for management services	A management company should not make above-market loans to a medical practice
Monies earned from the provision of patient services should be kept within the medical practice and used to pay salaries, bills, and other medical practice expenses	If possible, medical practice should not contract with the management company that also leases space and equipment to the medical practice

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inject an inappropriate level of control through a structure of interconnected MSO contracts that has the practical effect of usurping control over the clinical aspects of the medical practice. Indeed, if drafted and implemented properly, a clear delineation of roles will be the best defense against an allegation that the arrangement is nothing more than a sham.

This was the dilemma faced by the Court in *Northfield Medical Center*. Through an interwoven web of space rental leases, equipment leases, and management contracts, a chiropractor-owned management company was able to syphon profits from and maintain control over an affiliated medical practice. Although the majority of stock in the medical practice was owned by the physician, (1) the physician did not participate in day-to-day patient care, (2) medical practice profits were turned over to the management company in exchange for the provision of management services, leased space, and leased equipment, (3) the physician-owner of the medical practice signed an undated resignation letter and affidavit of non-issued or lost certificate bearing an unexecuted notary attestation for the physician's signature and date, which permitted the chiropractor to remove the physician, and (5) the leases between the management company and the medical practice included a "break fee" of $100,000 intended to penalize the medical practice's physician-owner for breaking the lease.

Based on these facts, the trial court found that the lawyer and chiropractor defendants violated the Insurance Fraud Prevention Act ("IFPA"), found at N.J.S.A. 17:33A-1 to -30, by knowingly assisting a New Jersey chiropractor in the creation of an unlawful multi-disciplinary practice, which had submitted medical insurance claims to Allstate. The trial court further found that the practice structure, which the defendant lawyer and chiropractor promoted and created, was designed to circumvent the CPOM doctrine and its requirements that relate to control, ownership, and direction of a medical practice.

While the Appellate Division reversed, finding a lack of evidence of intent, the New Jersey Supreme Court disagreed, finding that a fact-finder could reasonably conclude the structure was "little more than a sham intended to evade well-established prohibitions and restrictions governing ownership and control of a medical practice by a non-doctor." Physicians, limited-licensed professionals, and lawyers alike are on notice that they will be imputed with knowledge of what the CPOM law requires, and conduct intended to protect an investment and circumvent these rules will not be tolerated.

In the wake of the *Northfield Medical Center* decision, hospitals, physicians, MSOs, and private equity funds should keep in mind the do's and don'ts found on page 29 when structuring their arrangements to comply with New Jersey CPOM rules.

The CPOM doctrine comes into play in virtually every multi-disciplinary practice structure, management contract negotiation, and private equity transaction. In all circumstances, control over and supervision of the clinical aspects of the medical practice and patient care must remain with the plenary licensed physician. By following these simple do's and don'ts, the ownership, control, and direction of a medical practice will stay in the hands of the plenary licensed physician-owner, giving the MSO structure the greatest chance of being upheld by a court if ever challenged.

About the Author

James A. Robertson, Esq. is a Partner and Chair of the Healthcare Department at Greenbaum, Rowe, Smith & Davis LLP, where he concentrates his legal practice in the areas of healthcare transactional, regulatory and hospital reimbursement matters. He can be reached by email at jrobertson@greenbaumlaw.com.

Footnotes

[1]228 *N.J. 596* (2017).

Managing the Unmanageable
How to Navigate Your Payer Contracts and Reimbursement

Dan Marano

by Dan Marano, CHFP

Healthcare providers face a number of financial and operational challenges in today's healthcare landscape. From increasing operating and administrative costs to collections issues and a rapidly changing regulatory environment, a greater emphasis has been placed on providers to effectively manage their payer contracts. However, the process to maximize reimbursement and contract terms begins long before negotiations with payers. Providers must proactively evaluate their current contracts, analytical capabilities, relationships with payers, and their strategic goals to achieve strong agreements.

In order to develop a payer strategy, the first step is to understand your current reimbursement structure and contract terms. Providers should take inventory of their agreements, renewal dates, reimbursement structures, and contract language. Providers must be diligent when they can initiate renegotiations, otherwise, they risk delaying potential rate updates. Additionally, reimbursement can vary not only from payer-to-payer but also by network type (i.e., PPO, HMO, Medicare Advantage, etc.) and reimbursement structure (fee-for-service, shared savings/risk, bundled payments, capitation, etc.). Providers must also assess their current contract language and the impact it may have on their current operations such as, for example, their merger and acquisition strategy, claim submission procedures, and payment dispute policies. This work can be time consuming; however, it is required to effectively assess your current performance.

Once providers understand their current contract terms, it's essential to begin the process of evaluating the agreements in order to develop a robust payer strategy. Providers must ensure that they can utilize analytics to make data-driven decisions. The required analytical capabilities may include comparing current rates to Medicare rates, evaluating costs against reimbursement, tracking quality metrics over time with industry comparisons, as well as monitoring potential shared savings and losses. This data will serve as a guide to help providers evaluate the performance of their current agreements and to evaluate how they may compare to the market. If providers have difficulty pulling these metrics, it's important to partner with a vendor who can assist as these data are vital for providers to set strategic targets in their payer proposals.

To optimize payer relationships before submitting proposals, providers must connect with their payer representatives. Having conversations with payers regarding their strategic goals and how you can align with those goals will ensure that your organization is a valuable part of their provider network. If payers highlight specific quality metrics that they track internally and use in their own evaluation process, providers should explore their capabilities to track those metrics themselves. In addition, providers should strengthen ties across the industry by exploring partnerships with health systems, ACOs, and specialist groups in order to develop a unified coalition to drive value within the payer networks.

Based on all this information, providers should outline specific requests in their proposals to initiate negotiations. It's important to highlight the data that supports these requests and how your request will improve patient care and financial stability. Providers should remember that they are forming a partnership with payers and they must ensure that any new agreements can be strategically advantageous for all parties.

About the Author

Dan is the Senior Manager of the Healthcare Management Consulting division at Lighthouse Healthcare Advisors. Dan is a Certified Healthcare Financial Professional and is experienced in managed care contracting, revenue cycle, M&A due diligence, and performance improvement. He graduated from Franklin & Marshall College with a major in public health and is a member of the Healthcare Financial Management Association (HFMA). Dan can be reached at dmarano@lighthouseha.com.

Unlocking Revenue Potential: Maximizing Efficiency and Boosting Revenue in Healthcare Systems

Wyley McCoy

Fatimah Muhammad

by Wyley McCoy, PharmD, MBA & Fatimah Muhammad, MPH

"Unlock It: Maximize Efficiency to Minimize Medication Costs and Increase Revenue" will be presented at the 47th Annual Institute, Wednesday, September 27 at 2:30 p.m.

In the ever-evolving landscape of healthcare, revenue integrity has become an essential aspect of financial stability for healthcare systems. The challenge of reimbursements that fall short of medication costs and lead to financial strain is a cause of anxiety across the industry.

This article explores the crucial role of revenue integrity and the ways health systems can maximize efficiency, reduce medication costs, and increase revenue. We will examine St. Peter's Healthcare System's successful implementation of The Craneware Group's solutions to drive revenue while optimizing their medication revenue cycle.

Revenue integrity in healthcare refers to the comprehensive approach taken by healthcare organizations to ensure accurate billing, appropriate reimbursement, and proper utilization of resources. When healthcare facilities experience gaps and silos in their processes, it becomes challenging to achieve optimal performance in medication revenue cycles. Manual and complex data collection processes further compound these issues, making it difficult to identify opportunities for improvement.

Recognizing the critical need to address revenue integrity, St. Peter's Healthcare System has undertaken strategic initiatives to enhance efficiency, reduce medication costs, and boost revenue, with the primary focus of streamlining. The primary focus is on streamlining medication revenue cycle management, formulary management, and optimizing Group Purchasing Organization (GPO) contract opportunities.

Medication Revenue Cycle Management

St. Peter's Healthcare System is dedicated to developing a targeted approach to medication revenue cycle management. By closely monitoring and analyzing the revenue cycle, they are identifying areas of improvement, minimizing reimbursement gaps, and increasing overall revenue. This proactive approach not only improves the financial health of the organization but also ensures the availability of resources for better patient care.

Hospital Pharmacy Formulary with Reimbursement Analyses

The hospital pharmacy formulary is a key element in managing medication costs. By conducting regular reimbursement analyses, St. Peter's Healthcare System ensures that the formulary is optimized to align with cost-effective medication options while meeting patient needs. This strategic alignment of formulary and reimbursements helps control expenses without compromising on the quality of patient care.

Wholesale Acquisition Cost (WAC) Monitoring and Management:

Medication costs continue to rise exponentially, making it crucial for health systems to keep a close eye on Wholesale Acquisition Cost (WAC). St. Peter's Healthcare System actively monitors and manages WAC to identify cost-saving opportunities, negotiate with pharmaceutical manufacturers, and secure more favorable pricing. By doing so, they can effectively

manage expenses while maintaining the highest standard of patient care.

Optimizing GPO Contract Opportunities:

Collaborating with Group Purchasing Organizations (GPOs) can provide health systems with valuable leverage in negotiating favorable contracts with suppliers. St. Peter's Healthcare System proactively identifies and capitalizes on GPO contract opportunities, resulting in cost savings and enhanced revenue.

In the quest for financial sustainability, revenue integrity emerges as a fundamental pillar in the healthcare industry. St. Peter's Healthcare System exemplifies the tangible clinical, financial, and operational benefits of adopting The Craneware Group's solutions to streamline processes, optimize medication costs, and boost revenue, thus enabling them to provide better patient care and drive overall financial performance.

About the Authors

Wyley McCoy, PharmD, MBA, is Senior Vice President, Medication and Supply Portfolio at The Craneware Group. He can be reached at wmccoy@sentryds.com.

Fatimah Muhammed 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.

Aligning Financial and Clinical Data to Create Actionable Information in Medical Groups

Amato Amarain

by Amato Amarain

As medical groups of all sizes and affiliations continue to struggle with operating margins, the need to better understand your business in a timely and accurate manner becomes imperative. Physician enterprise data is complicated from both a financial and clinical perspective and the effort to gather and report data is a time-consuming process. Measuring the value of the investment in physician practices requires a comprehensive understanding of professional billing and ambulatory operations. Aligning disparate data is essential to ascertaining performance of a medical group's aligned physicians within the organization and then arranging the information to properly interpret performance to make strategic business decisions.

There are several cost-effective business intelligent strategies which can be deployed to simplify the data gathering process. These strategies should consider maintaining consistent data governance and ensuring data integrity while also maintaining key stakeholders trust in the data and the ability to take appropriate and timely action to improve financial and clinical performance. Organizing data in a user-friendly environment allows decision-makers to utilize robust performance indicators that consolidate clinical and financial data. Also using varying benchmarks to measure performance trends helps create a culture of ongoing review of the information that is available to leadership, staff and physicians. Robust, accurate and timely data is essential for leaders to come to understand the facts provided in an intuitive reporting structure.

[C]ost-effective . . . strategies . . . should consider maintaining consistent data governance and ensuring data integrity while also maintaining key stakeholders trust in the data and the ability to take appropriate and timely action to improve financial and clinical performance.

About the Author

Amato Amarain is the President and CEO of Amato Consulting Group. He was recently the Chief Financial Officer of the Combined Medical Group of RWJBarnabas Health and Vice President of Finance for Northwell Health Physician Partners. Amato has served in health care finance leadership and consultancy roles for more than 30 years with strong expertise in data analytics and ambulatory practice finance. He can be reached at amatoconsultinggroup@gmail.com.

Considerations for M&A Transactions in the Healthcare Industry

Steve Brady

Michael Ritchie

by Steve Brady and Michael Ritchie

Mergers and acquisitions in the healthcare industry have significantly increased over the past several years across all subsectors from national and regional hospitals and healthcare systems to healthcare-specific technology companies and private physician practices. The increase in activity has been driven by private equity continuing to gain momentum in the healthcare industry and the continuation of healthcare systems expanding their footprint through acquisitions of private physician practices. M&A in the healthcare sector has continued to remain robust in 2023 while the overall M&A market has taken a breather over economic uncertainties related to inflation and increased interest rates from the Federal Reserve. However, the life cycle of the deal has lengthened as the diligence process has become more highly scrutinized by lenders and investors.

The diligence process consists of several different teams focusing on financial information, revenue cycle, taxes, legal, regulatory, technology, cyber, and operations. When preparing your organization to go to market it is critical to have a proper advisory team to support your business throughout the deal life cycle and increase the odds of having a favorable and successful transaction consummated.

To transact a successful and favorable deal for your business, it is important to focus on the following:

- Assess how to construct and present EBITDA to optimize deal value
- Set a net working capital peg to limit last-minute negotiation before closing
- Understand how structuring will be impacted by diligence and regulatory matters
- Identify benefits, challenges and potential pitfalls of a transaction
- Execute post-acquisition operational and system integration opportunities

About the Authors

Steve Brady is Partner and Market Leader, Transaction Advisory Services at Withum and can be reached at sbrady@withum.com.

Mike Ritchie is Senior Manager at Withum and can be reached at mritchie@withum.com.

Recent Developments in Federal and State Fraud and Abuse Investigations

Jack Wenik

by Jack Wenik

The emphasis and targets of Federal and State fraud and abuse investigations constantly shift in response to statutory/regulatory changes, political changes, and changes in the healthcare landscape. The Department of Justice ("DOJ") under the Biden Administration has altered its enforcement priorities generally, and in the healthcare space particularly, with varying degrees of success. The recent election of a Republican-controlled House of Representatives has also had an important effect of putting the brake on some major proposed statutory/regulatory changes in the healthcare space. Perhaps most importantly, Secretary of Health and Human Services Xavier Becerra announced, effective May 11, 2023, the end of the Public Health Emergency, which had been imposed as a result of COVID-19.[1] All of this has had significant effects on fraud and abuse investigations.

Medicaid Beneficiary Fraud

One of the consequences of the imposition of the COVID-19 public health emergency ("PHE") was that, per the instructions of CMS, for the duration of the PHE, states were required to maintain the enrollment of all Medicaid enrollees. The results were predictable. Medicaid rolls ballooned to a record 85 million individuals. Because of the moratorium on eligibility redeterminations, 24 million people were added to the rolls.[2] According to the Urban Institute, 15 million Medicaid enrollees nationally are ineligible for benefits.[3]

The end of the PHE brings with it the elimination of the moratorium on eligibility determinations. As a result, in New Jersey, eligibility redeterminations for 2 million people began on April 1, 2023.[4] Thus, we can expect in the future that many thousands of individuals who do not qualify for the program because of their income or assets will ultimately be purged from the Medicaid rolls. While to be sure, many of these enrollees did not act with fraudulent intent, others did. Criminal Medicaid Fraud Control Units typically limit their activities to investigating provider, not beneficiary fraud. Investigating beneficiary fraud is left to other regulatory entities or local prosecutors' offices. In New Jersey, the civil Medicaid Fraud Division of the Department of State has conducted beneficiary fraud investigations in the past. With the lifting of CMS's moratorium on eligibility redeterminations, we can expect them to do so again.

Also of interest on the Medicaid beneficiary front is the continuing saga of "Work for Medicaid." As this author has noted in prior issues of *Garden State Focus Magazine,* a rapidly expanding effort to impose work requirements on able-bodied Americans receiving Medicaid benefits was dramatically reversed with the election of President Biden. The Biden Administration, however, has not been entirely successful in this regard. Georgia successfully litigated the federal government's attempt to cut-off its Medicaid work requirements. While Georgia's program began in the summer of 2023, it is yet to be seen whether it will produce any fiscal savings.[5]

"Work for Medicaid" continues to be a goal of Republican legislators. Republicans pushed for the enactment of nationwide "Work for Medicaid" requirements as part of the debt ceiling negotiations.[6] While unsuccessful in their initial efforts to implement the "Work for Medicaid" concept, it is unlikely that Congress will give up on the initiative. The costs of Medicaid are enormous and on a continued upward trajectory, making the enactment of some sort of reform essential.

For providers, this new focus on beneficiaries makes it of the utmost importance to verify the Medicaid eligibility and coverage of patients. In extreme cases where providers turn a blind eye to beneficiary fraud, they could face potential exposure as accessories to beneficiary fraud. Finally, if "Work for Medicaid" programs

are enacted, with their accompanying requirements to document work, community service or educational efforts, it opens up an entirely new category of fraud and abuse investigations.

Department of Justice Initiatives

On February 22, 2023, pursuant to the direction of Deputy Attorney General Lisa O. Monaco, a uniform Voluntary Self-Disclosure Policy was promulgated for United States Attorney's Offices.[7] This development is important for corporate and other organizations that provide healthcare services. Pursuant to the policy, a United States Attorney's Office will **not** seek a corporate guilty plea from those entities that have promptly self-disclosed, cooperated fully with the government's investigation, and remediated the criminal conduct at issue, absent other aggravating factors.[8] Of course, as with all government policies, the "devil is in the details" and, for example, whether or not disclosure has been "prompt," or an organization has "fully" cooperated with a government investigation will no doubt be the subject of some debate in particular cases. Nevertheless, the promulgation of formal standards wherein the federal government will not prosecute certain criminal conduct is a significant development that in-house counsel and compliance officers should follow closely.

With regard to healthcare fraud, DOJ's focus is on illegal opioid prescriptions, COVID-19 related fraud, and telemedicine fraud (which is closely linked to fraud regarding clinical laboratories and durable medical equipment ("DME")). In 2022, DOJ formed yet another unit to combat illicit opioid distribution, the New England Prescription Opioid Strike Force or "NEPO." This unit joins several others such as the Appalachian Regional Prescription Opioid Strike Force, "ARPO" in tackling the illegal opioid trade. Needless to say, all providers must track opioid prescriptions and the documentation for same diligently and take prompt action if suspicious prescribing patterns are observed.

The advent of COVID-19 has made telemedicine more mainstream, and CMS has loosened previous restrictions regarding access and reimbursements for telemedicine. No doubt this is, for the most part, a positive development, increasing access to healthcare services and in many cases reducing costs. On the negative side, because telemedicine is more difficult to monitor and verify, it is inherently more susceptible to fraud. This has been particularly true with regard to authorizations for genetic testing, often referred to as CGX, which have been the subject of DOJ's operation "Double Helix," ongoing since 2019. DOJ statistics for 2022 allege $1.2 billion in fraud related to telemedicine fraud.

As for COVID-19 fraud, the Coronavirus Aid, Relief, and Economic Security Act ("CARES") passed in March 2020, along with other relief measures, provided enormous sums of government money intended to protect the economy. Wherever there is a large government funded relief program, fraud surely follows. COVID-19 is no different except perhaps for the scale of the thefts/fraud being perpetrated. DOJ statistics for the first few months of 2023 allege $490 million in fraud related to COVID-19.

Finally, at the federal level, one of the most significant developments in healthcare fraud investigations is the recent unanimous Supreme Court decision in *Dubin v. United States*.[9] In *Dubin,* the Supreme Court considered the appropriateness of applying aggravated identity theft[10] to a run-of-the-mill overbilling case by a psychologist submitting improper bills to Medicaid. Aggravated identity theft carries a two-year mandatory prison sentence and federal prosecutors routinely used this charge as leverage in plea bargain negotiations for a wide variety of healthcare fraud prosecutions.

In *Dubin* the government argued that because patients' Medicaid reimbursement numbers were used as part of the billing fraud, aggravated identity theft applied. The Supreme Court unanimously rejected this noting that the government's theory would allow the use of this charge in every overbilling case. Instead, the Court held that the use of another person's identification must be the crux of what makes the conduct criminal. The *Dubin* decision thus levels the playing field somewhat, removing the threat of mandatory incarceration previously wielded by the prosecution in virtually all false or overbilling cases.

Data Security Issues

Since the implementation of HIPAA's privacy, security and breach enforcement rules in the early 2000s, it goes without saying that a healthcare provider of any appreciable size must maintain robust data security procedures. Developments of the past several months show that this is a topic increasingly on the minds of prosecutors and government regulators.

In March of 2023, the DOJ revised its guidelines for evaluating corporate compliance programs.[11] Of particular interest is the guidelines' emphasis on the accessibility, preservation and security of electronic information and communications. This applies not only to the databases and equipment of the company/organization but also to the personal devices of employees who use them for work purposes.[12]

Government officials expect healthcare providers to be proactive in the protection of data, particularly individuals' personal health information, or face administrative and other enforcement proceedings. An example of this is reflected in the Federal Trade Commission's ("FTC") July 20, 2023 warning letters sent to numerous hospital systems and telehealth providers.[13] The FTC letter cautioned healthcare providers to disable tracking technologies present on their mobile applications and websites lest they reveal consumers' personal health information to third parties.

The takeaway? Healthcare providers cannot assume that inadvertent data security lapses will not subject them to govern-

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ment enforcement actions or scrutiny. Rather, robust protections must be in place and proactive policies and procedures employed. Otherwise, even inadvertent data security lapses will create exposure for providers.

The Antitrust Division's War Against Healthcare Providers

The election of President Biden brought a significant change in United States antitrust policy. In a dramatic departure from prior administrations, antitrust enforcement has been brought to the forefront at both the FTC and the DOJ's Antitrust Division. Mergers are now subject to intense scrutiny. In the healthcare space this was demonstrated by last year's failed merger of Saint Peter's Health Care System and RWJBarnabas Health in the face of opposition by the FTC. Less well known is the Antitrust Division's new criminal focus on the healthcare industry.

In October 2016 the FTC and the Antitrust Division released guidance for human resource professionals.[14] The guidance cautioned companies/organizations that agreements to fix wages and/or not to hire competitors' staff ("no-poach" agreements) were illegal. Indeed, even the sharing of wage information with other companies could be problematic.

While not specifically addressed to healthcare companies/entities, these guidelines have received new emphasis in the healthcare space during the Biden administration,[15] with a slew of criminal cases alleging theories of either wage-fixing or no-poach agreements being brought against healthcare companies/providers.

The results to date have been a disaster for the Antitrust Division with multiple acquittals during or after trial in the cases brought so far. No less than 5 major healthcare antitrust prosecutions have resulted in acquittals in 2022 and 2023. Indeed, the Antitrust Division has yet to succeed at trial in any wage-fixing or no-poach prosecution against a healthcare provider.

Nevertheless, the Antitrust Division continues to bring these sorts of cases and shows no sign of backing away from these theories of liability. Healthcare entities must be vigilant not to share wage or other sensitive employee information with other companies, even if they may not, at first glance, seem to be direct competitors.

Conclusion

Fraud and Abuse investigations in the healthcare space will only increase as this industry consumes a greater and greater proportion of government spending. Moreover, as political winds and priorities shift, so too will the emphasis and targets of such investigations change. Robust compliance and risk management functions are an indispensable necessity for all healthcare providers.

About the Author

Jack Wenik is a Member of Epstein, Becker & Green, P.C. Jack can be reached at jwenik@ebglaw.com.

Footnotes

[1]Letter to U.S. Governors from HHS Secretary Xavier Becerra on renewing COVID-19 Public Health Emergency. February 9, 2023, located at: https://www.hhs.gov/about/news/2023/02/09/letter-us-governors-hhs-secretary-xavier-becerra-renewing-covid-19-public-health-emergency.html.

[2]Wall Street Journal, August 15, 2022, Lead Editorial, *The Government's Stealth Health Takeover.*

[3]Urban Institute, *What Will Happen to Medicaid Enrollees' Health Coverage after the Public Health Emergency,* March 2022 at 2.

[4]Jennifer Langer Jacobs, *NJ Medicaid Resumes Eligibility Determinations April 1,* Garden State Focus Magazine, Winter 2022.

[5]*See, e.g.,* Pifer, Rebecca, *Georgia's Medicaid work requirements pricier, more restrictive than full expansion.* June 30, 2023, Healthcare Dive.

[6]*See,* H.R. 1551 introduced in the House of Representatives on March 10, 2023.

[7]The new policy can be found at: https://www.justice.gov/d9/2023-03/usao_voluntary_self-disclosure_policy_2.21.23.pdf.

[8]*Id.* at 4.

[9]*No. 22-10* (decided June 8, 2023).

[10]*See,* 18 *U.S.C.* § 1028A(a)(1).

[11]DOJ's Evaluation of Corporate Compliance programs can be found at: https://www.justice.gov/criminal-fraud/page/file/937501/download.

[12]*Id.* at 17-18.

[13]The FTC's warning letter can be found at: https://www.ftc.gov/system/files/ftc_gov/pdf/FTC-OCR-Letter-Third-Party-Trackers-07-20-2023.pdf.

[14]Antitrust Guidance for Human Resource Professionals can be found at: https://www.justice.gov/atr/file/903511/download.

[15]*See,* Executive Order No. 14036, 86 *Fed. Reg.* 36987 (July 9, 2021) (emphasizing antitrust enforcement in labor markets). *See, also,* December 9, 2022 DOJ Press Release announcing Memorandum of Understanding between the Antitrust Division and OIG for increased sharing of information/antitrust enforcement in healthcare markets. Located at: https://www.justice.gov/opa/pr/justice-department-s-antitrust-division-and-office-inspector-general-department-health-and.

Analytics and The Craneware Group: Optimizing Revenue Cycle for Value-Based Care

Pietro Ferrara

by Pietro Ferrara, Senior Vice President, Margin and Operational Intelligence Operations at The Craneware Group

Today's healthcare landscape is characterized by complexity and constant change, with providers facing mounting competitive, regulatory, and environmental pressures. Among those at the forefront of these challenges are financial and decision support executives, who are tasked with finding innovative ways to reduce costs, optimize care, and identify growth opportunities.

The transition to a value-based care and reimbursement environment has become imperative, requiring healthcare organizations to harness the power of analytics to develop effective strategies with measurable results. This article examines the importance of analytics in supporting the shift to value-based care and explores how The Craneware Group can play a significant role in optimizing revenue cycle management.

Traditionally, adopting advanced costing techniques and analytics has been considered cost-prohibitive for many healthcare organizations. However, a new era of Business Decision Support Solutions (BDSS) has emerged, making this once-challenging task more attainable at scale. With the help of BDSS, financial leaders gain unprecedented access to underleveraged electronic health record (EHR) data, paving the way for more informed and data-driven decision-making.

The transition to a value-based care and reimbursement environment has become imperative, requiring healthcare organizations to harness the power of analytics to develop effective strategies with measurable results.

The Power of Activity-Based Costing

Within the realm of costing methodologies, activity-based costing (ABC) stands out as a game-changer, offering the highest accuracy and deep insights into hospital operations and patient care costs. By adopting ABC, healthcare organizations can gain a comprehensive understanding of their cost structures, identify cost drivers, and uncover areas for improvement. This data-driven approach equips decision-makers with the necessary tools to optimize costs while delivering superior care.

Addressing Challenges Faced by Hospitals

Transitioning to value-based care comes with its own set of challenges, which many hospitals are currently grappling with. In this context, The Craneware Group plays a crucial role in enabling healthcare organizations to navigate these challenges. By leveraging BDSS and activity-based costing, The Craneware Group empowers financial leaders to make strategic decisions that lead to improved revenue cycle management and financial sustainability.

Preparing for At-Risk Reimbursement Environments

As healthcare organizations move towards value-based care, they inevitably encounter at-risk reimbursement environments. To succeed in this landscape, organizations must equip themselves with advanced analytics and underlying systems. Leveraging data-driven conversations with payors and fostering alignment within the organization are essential components of providing the most cost-effective care with superior patient outcomes.

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The Craneware Group's Role in Optimizing Revenue Cycle

A key player in the healthcare technology space, The Craneware Group offers comprehensive solutions for optimizing revenue cycle management. By integrating BDSS and activity-based costing, The Craneware Group empowers healthcare organizations to achieve operational efficiency, improved financial performance, and enhanced patient care. In the pursuit of value-based care and financial sustainability, analytics emerges as a critical enabler for healthcare organizations.

By adopting Business Decision Support Solutions and activity-based costing, financial leaders can make informed decisions that lead to cost optimization and high-quality care. The Craneware Group's comprehensive solutions play a pivotal role in optimizing revenue cycle management and enabling healthcare organizations to thrive in an ever-changing healthcare landscape. The future of healthcare lies in data-driven decision-making, and organizations that harness the power of analytics will be better equipped to succeed in the new era of value-based care.

New Jersey Healthcare Financial Management Association 2022-23 Chapter Awards Listing

President's Award
Fatimah Muhammad, MPH

Founders Merit Award - BRONZE
Jonathan Besler

Founders Merit Award - SILVER
Hayley Shulman
Lisa Schaaf
Maria Lopes-Tyburczy, CHFP

Member in a Non-Leadership Position
Hanna Hartnett

Wednesday, September 27th

Lunch	**11:30am to 12:30pm**		**BallRoom**
Kickoff Session	**12:00pm to 1:00pm**	**(1 CPE)**	**BallRoom**
It's Time			
Dennis Dahlen, HFMA National Chair, CFO, Mayo Clinic			
Networking Break	**1:00pm to 1:30pm**		**Vendor Hall**
Breakout #1	**1:30pm to 2:20pm**	**(1 CPE)**	
Collaboration Strategies with Your Outsourced Revenue Cycle Management Vendor			**Room 1**
Caroline Rader Znaniec, Protiviti			
The Conclusion of the Public Health Emergencies: What This Means for Healthcare Providers			**Room 2**
Jim Robertson and John Kaveney, Greenbaum, Rowe, Smith & David LLP			
The New Clean Energy Tax Credits Opportunities for Healthcare Systems			**Room 3**
Phillip Groff, KPMG			
Transtion between Breakouts	**2:20pm to 2:30pm**		
Breakout #2	**2:30pm to 3:20pm**	**(1 CPE)**	
Unlock It: Maximize efficiency to minimize medication cost and increase revenue			**Room 1**
Fatimah Muhammad, Saint Peter's University Hospital			
Wyley McCoy, The Craneware Group			
Transmittal 18 - Changes and How Hospitals Can Prepare			**Room 2**
Scott Besler, Toyon Associates			
Fred Fisher, Toyon Associates			
Maintaining Debt Covenant Compliance Through Performance Improvement			**Room 3**
Kelly Smith, FORVIS			
Mike Zablocki, FORVIS			
Networking Break and Snack	**3:20pm to 3:50pm**		**Vendor Hall**
Breakout #3	**3:50pm to 4:40pm**	**(1 CPE)**	
The Financial and Operational Impact of the Credentialing Process			**Room 1**
Belinda Doyle Puglisi, RWJ Barnabas Health			
George Kelly, CBIZ			
Walking Through The Minefield: Preparing For The Challenges Of A New Physician Compensation Model			**Room 2**
Rudd Kierstead, Veralon Partners, Inc.			
Outsmart denials + protect your organization's earned revenue			**Room 3**
Christine Fontaine, Waystar			
Charity Event	**5:30pm to 7:30pm**		**Vendor Hall**
Fundraiser for the Glioblastoma Foundation			
Cocktail/Hors d'oeuvres Reception			

Thursday, September 28th

Buffet Breakfast	**8:00am**		**BallRoom**
Chapter Awards	**8:45am to 9:00am**		**BallRoom**
General Session	**9:00am to 9:50am**	**(1 CPE)**	**BallRoom**
Bridging the Gap Between Revenue Cycle and Case Management			
Ronald Hirsch, R! RCM			
General Session	**9:50am to 10:40am**	**(1 CPE)**	**BallRoom**
Medicaid Redetermination			
Day Egusquiza, AR Systems, Inc. & Patient Financial Navigator Foundation, Inc.			
Networking Break & Snack	**10:40pm to 11:00pm**		**Vendor Hall**
Keynote Session	**11:00am to 12:00pm**	**(1 CPE)**	**BallRoom**
New Jersey Healthcare			
Robert Garrett, Hackensack Meridian Health			
Buffet Lunch	**12:00pm to 1:00pm**		**BallRoom**
Breakout #4	**1:05pm to 1:55pm**	**(1 CPE)**	
Managing Personnel through Analytics - Workforce Management			**Room 1**
Kasandrah Garnes, Novartis			
Ed Laus, Novartis Patient Service Center			
Key Considerations for Building an Enterprise Privacy and Security Culture of Governance,			**Room 2**
Safeguards and Compliance			
Gerry Blass, Comply Assistant			
Jim Cavanaugh, Executive Healthcare Consulting			
Jack Hueter, Digital Health Consulting			
Considerations for M&A Transactions in the Healthcare Industry			**Room 3**
Steve Brady, Withum			
Managing the Unmanageable: How to Navigate your Payer Contracts and Reimbursement			**Room 4**
Daniel Marano, Lighthouse Healthcare Advisors			
Transtion between Breakouts	**1:55pm to 2:00pm**		

Thursday, September 28th

Breakout #5	**2:00pm to 2:50pm**	**(1 CPE)**	
Healthcare Hot Topics: You literally cannot afford to miss this			**Room 1**
Jeny McNair, Physician Advisor On Call			
Recent Developments in Federal and State Fraud and Abuse Investigations			**Room 2**
Jack Wenik, Epstein Becker & Green			
Aligning Clinical and Financial Data to Create Actionable Information in Medical Groups			**Room 3**
Amato Amarain, Amato Consulting Group			
How Finance Leades can Improve the Bottom Line with Clinical Knowledge			**Room 4**
Glenn Kruass, Core-CDI			
Doug Cutler, MD, Yavapai Regional Medical Center			
Jacob Martin, Core-CDI			
Ice Cream Social	**2:50pm to 3:10pm**		**Vendor Hall**
Breakout #6	**3:10pm to 4:00pm**	**(1 CPE)**	
Improving Operations Through CFO/CIO Collaboration			**Room 1**
Rich Temple, Deborah Heart and Lung Center			
Artificial Intelligence (AI) in the Healthcare Revenue Cycle			**Room 2**
Matthew Schwartz, FTI Consulting			
Team Work Makes the Dream Work: How Compliance and Revenue Integrity Can Partner on Investigations			**Room 3**
Melanie Sponholz, Waud Capital Partnets			
Leslie Boles, Revu Healthcare, LLC			
Hayley Marsh, Waud Capital Partners			
Do Your Analytics Support the Transition to Value-Based Care?			**Room 4**
Pietro Ferrara, The Craneware Group			
Naveed Ismail, The Craneware Group			
Transtion between Breakouts	**4:00pm to 4:10pm**		
Roundtable Discussion	**4:10pm to 5:25pm**	**(1.5 CPE)**	
Revenue Cycle Roundtable			**BallRoom**
Anne Goodwill-Pritchett, Hackensack Meridian Health			
Sandy Gubbine, AtlantiCare			
Steven Honeywell, University of Pennsylvania Health System			
Christy Pehanich, Geisinger Health System			
Joe Scargle, RWJ Barnabas Health			
President's Reception	**6:00pm to 8:00pm**		**Borgata Indoor Pool and Garden**
Late Night Dance Party	**10:00pm to 1:00am**		**Premier Night Club**

Friday, September 29th

Buffet Breakfast	**8:00am**		**BallRoom**
General Session	**9:00am to 9:50am**	**(1 CPE)**	**BallRoom**
TBD			
General Session	**9:50am to 10:40am**	**(1 CPE)**	**BallRoom**
Equity, Diversion and Inclusion: The New Frontier			
Deborah Visconi, Bergen New Bridge Medical Center			
Barbara, Piascik, Bergen New Bridge Medical Center			
Break	**10:40pm to 10:50pm**		**BallRoom**
Roundtable Discussion	**10:50am to 12:05pm**	**(1.5 CPE)**	**BallRoom**
CFO Panel			
Bob Segin, Virtua Health Syetem			
Spencer Kowal, Geisinger Health System			

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2023 Chapter Internal Financial Review

HFMA requires that each Chapter conduct either an independent audit or an HFMA internal financial review. The HFMA internal financial review process and reporting were developed by HFMA and must be followed by any Chapter opting for this approach instead of an independent audit. Pursuant to HFMA's requirements, the internal financial review must be completed by an individual or individuals possessing the appropriate financial experience and who are not involved in the Chapter's bookkeeping activities.

The purpose of the internal financial review is to test and validate the Chapter's fiscal integrity and operating guidelines. Furthermore, the review

- Addresses whether the Chapter's financial statements correctly reflect the activities for the year.
- Consider whether an adequate level of documentation is maintained for the Chapter's receipt and disbursement transactions in order to reconcile checking and saving account bank statements.
- Considers whether transaction approval guidelines are in place and being observed.

The internal financial review for the 2022–2023 Chapter Year was completed on a voluntary basis by a retired CFO and Chapter member wth 40 years of healthcare financial management experience. The Chapter Treasurer, the Assistant Treasurer and Officers provided the necessary documentation required for the internal financial review. The completed internal financial review questionnaire was provided to the Chapter's Audit Committee of the Board of Directors. A meeting of the Audit Committee was held to review the findings and the questionnaire. Upon review, the Audit Committee accepted the internal financial review findings and approved the financial statements for the 2022–2023 Chapter Year.

The accompanying balance sheets and statements of activities and cash flows for the years ended May 31, 2023, 2022 and 2021 reflect the financial statements for the NJ Chapter. If you should have any questions, please feel free to reach out to any Board member for assistance.

Respectfully submitted,

Jill Squiers
2022-2023 Audit Committee Chair
NJ HFMA

Healthcare Financial Management Association - New Jersey Chapter
Balance Sheets

	As of May 31		
	2023	2022	2021
Assets			
Current Assets			
Bank accounts	$371,192	$246,995	$254,663
Accounts receivable, net	9,839	14,380	2,800
Other current assets	6,908	1,980	12,247
Total current assets	387,939	263,355	269,710
Investments	23,812	24,104	25,867
Fixed assets	-	-	-
Total assets	$411,751	$287,459	$295,577
Liabilities and net assets			
Liabilities			
Current liabilities			
Accounts payable	$28,066	$168	$4,290
Deferred revenue	56,836	2,500	14,646
Accrued payroll	-	5,684	1,957
Total current liabilities	84,902	8,352	20,893
Total liabilities	84,902	8,352	20,893
Net assets			
Net assets without restriction	326,849	279,107	274,684
Total liabilities and net assets	$411,751	$287,459	$295,577

Healthcare Financial Management Association - New Jersey Chapter
Statements of Activities

	Year ended May 31		
	2023	2022	2021
Income			
Meeting and education income	177,820	106,638	675
Newsletter income	5,240	17,220	16,980
Golf Outing Income	45,300	55,475	35,690
General sponsorship income	157,450	189,289	77,781
Interest income	4,087	422	80
Other income	23,390	-	166
Total income	413,286	369,044	131,372
Expenses			
Meeting and education expenses	286,932	271,464	43,951
Newsletter expenses	4,537	14,239	18,286
Golf Outing expenses	28,854	30,896	26,900
Member recognition and social event expenses	7,553	6,899	2,070
General and administration expenses	37,127	39,133	40,227
Provision for bad debts	-	-	595
Total expenses	365,002	362,630	132,029
Net Operating Gain/(Loss)	48,284	6,414	(657)
Unrealized gain and loss	(542)	(1,991)	903
Net income (loss)	47,742	4,423	246

Healthcare Financial Management Association - New Jersey Chapter
Statement of Cash Flows

	Year ended May 31		
	2023	2022	2021
Operating activities			
Net income (loss)	47,742	4,423	246
Adjustments to reconcile net income (loss) to net cash provided by (used in) operations:			
Change in unrealized gains (net)	542	1,991	(903)
Accounts receivable, net	4,542	(11,580)	(2,015)
Other current assets	(4,928)	10,267	10,777
Accounts payable	27,898	(4,122)	2,369
Deferred Revenue	54,336	(12,146)	(542)
Accrued Payroll	(5,684)	3,727	(85)
Net cash used in provided by (used in) operating activities	124,447	(7,441)	9,847
Cash flows from Investing Activities			
Purchases of Investment, net	(250)	(227)	(24,964)
Net decrease in cash	124,197	(7,668)	(15,117)
Cash at beginning of period	246,995	254,663	269,780
Cash at end of period	371,192	246,995	254,663

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Holiday Networking Pizza Party & Toys for Tots Drive

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Registration opening soon on our website, hfmanj.org

Stay up to date on all of our events, follow us on social media
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We are seeking members to join us to help produce our quarterly award winning newsletter/magazine, The Garden State Focus.

Contact Laura Hess at NJHFMA@aol.com for more info.

• HFMA NEW JERSEY •

ENGAGE WITH US!

Make your HFMA membership work for you by actively participating in the New Jersey chapter. Here are some of the many benefits of engaging with us!

LEARNING

Participate in our committees to discuss and receive up-to-date information on issues relevant to your area of work.

NETWORKING

Attend our education and networking events to build valuable connections with healthcare industry experts.

CAREER ADVANCEMENT

Build your resume and network by volunteering with us. Don't forget to take advantage of the free certifications HFMA membership offers!

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