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Winter 2023/2024 • vol 70 • num 2

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- 47th Annual Institute Recap
- What's Next in 2024?

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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

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The President's View . . .

Heather Stanisci

Dear NJ HFMA Members,

As I embark on the second half of my term as President of the New Jersey HFMA, I am brimming with excitement for the outstanding events we have planned in 2024. I extend my heartfelt gratitude to the Board, Committee Chairs and Co-Chairs, Volunteers, Members, and Sponsors for your continued dedication to the success of the New Jersey Chapter.

It is a profound honor to lead our esteemed organization, and together, we have molded the NJ HFMA into a thriving community rooted in collaboration, professional development, and an unwavering commitment to excellence. This year, our chapter is focused on enhancing Education Value and cultivating member and volunteer engagement. To realize these objectives, we have a multitude of education and networking events planned. Through this emphasis, our aim is to shape a chapter that fosters meaningful connections and empowers each member to ascend to new heights in their healthcare financial-management journey.

We commence the calendar year with the PFS/PAS session on January 11, 2023. Additionally, two exciting networking events are in the pipeline: a Super Bowl Themed Virtual cooking webinar on January 24th and a joint networking event in Morristown with the NJ chapter of ACHE on March 7th. Our Annual Cost Report update Webinar is scheduled for February 22, and the ever-popular Women's Session (open to all!) is on the horizon. Let us not overlook the Golf Outing slated for May 9th as well as the 48th Annual New Jersey Metro Philadelphia Annual Institute scheduled for October 9–11, 2024, set against the vibrant backdrop of the new rocking venue, the Hard Rock Casino, and Hotel in Atlantic City.

I am steadfast in my commitment to upholding the legacy and promoting the future of NJ HFMA while fostering an environment where every member can contribute, learn, and flourish. Your active involvement is pivotal to our organization's success, and I encourage you to engage with our committees, participate in our educational events, and relish the networking opportunities throughout the upcoming chapter year.

Thank you for your ongoing support, and I eagerly anticipate the accomplishments and growth that we will achieve together in the coming year. Here's to a fantastic year ahead!

Warm regards,

Heather Stanisci
President, NJ HFMA

From The Editor . . .

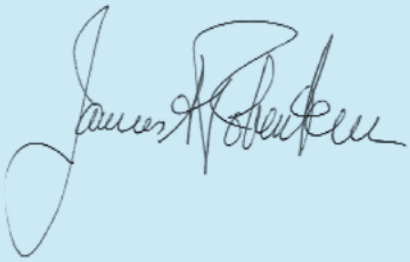
James Robertson

We, the Communications Committee, are pleased to provide you with the Winter 2023/2024 issue of Garden State *FOCUS*! This issue kicks off with a recap of the 47th Annual Institute by none other than our very own Mike McKeever, followed by an in-depth interview of St. Peter's University Hospital's Susan Klein and Kaitlyn Senatra for their insights into revenue cycle operations, conducted by Fatimah Muhammad and Denny Henderson. This issue also contains informative articles on unraveling the Inflation Reduction Act, how healthcare organizations should prepare for life after the end of the public health emergency, an informative synopsis of two CMS webinars on the uncertain economic and political landscape of Medicare reimbursement policy initiatives, and a thought-provoking article on navigating the uncertainty of State abortion laws. We are so very fortunate to have authors who are so generous with their time and talent to enable us to provide you with this high-quality magazine. Thank you to everyone who has contributed to this issue.

But, perhaps as equally exciting is the trial run of a new format for *FOCUS* Magazine. Using a platform called Flip Docs, we have made this e-version of *FOCUS* available to read more like a traditional magazine rather than a standard PDF and hope your user experience is enhanced and simply more fun as a result. We welcome your feedback on this new format and encourage you to let us know how you like it.

Finally, and most important, the Communications Committee would like to wish all our members and their families a very joyous Holiday Season and a Happy and Health New Year!

Cheers!



47th Annual Institute – It's Time

Michael McKeever

by Michael P. McKeever, FHFMA, CPA

With the memories of summer still fresh, 430 registrants gathered at the Borgata in Atlantic City from September 26 – 29 for the New Jersey and Metropolitan Philadelphia HFMA Annual Institute. The Institute Committee, comprised of members from both Chapters who had been planning the event for months, had much to be proud about as the 47th Annual Institute exceeded all expectations in the educational content delivered and the networking events that are always so popular. Many things had that familiar feel, but there were enough new experiences to make this truly an event to be remembered.

Wednesday Afternoon

New Jersey Chapter President, Heather Stanisci, started the event by welcoming the attendees and thanking the sponsors for their support of this year's Institute. Lunch was served at 11:30, with Dennis E. Dahlen, HFMA Chair and Chief Financial Officer of Mayo Clinic presenting the Chair's Theme, It's Time, at noon. After explaining his HFMA journey, Dennis explained this year's theme, and the importance of strong leadership in transforming the healthcare delivery system to meet the challenges we all currently face. He referenced a recent New York Times article that showed that beneficiary Medicare spending had declined recently, and that the Association is working to help understand why this is happening. Recognizing the pressure to change, Dennis left the audience with the message that it was time; to reflect, to celebrate, to onboard and to act.

After a short networking break wherein the attendees were encouraged to enjoy a snack and visit the sponsor booths, a series of three breakout sessions were held, with another networking break mid-afternoon. Topics for the breakout sessions included outsourcing revenue cycle management, artificial intelligence, the clean energy tax credit, medication costs, Transmittal 18, debt covenant compliance, the credentialing process, new physician compensation models, and managing payer denials. As always, the Education and Annual Institute committees went to great lengths to identify topics across a broad spectrum of interest so that there would be something of value for all attendees.

Wednesday Night

Wednesday night's Charity Event benefited the Glioblastoma Foundation. This organization is near and dear to NJ Chapter President Heather Stanisci's heart in that her father had recently passed away from this horrible disease. The event raised over $5,000 to assist with the important work done by the Foundation, which supports the development of targeted therapies for this often fatal disease. Funds were raised through a silent auction, whereby attendees were able to try and win unique and valuable prizes donated by the sponsors and friends of the Chapter, as well as a 50/50 raffle where the prize was the always popular cash. It was a fun-filled night, as the pictures following this article will show. Participants enjoyed tasty hors d'oeuvres and refreshing libations that brought an end to the first day of the Annual Institute, although I sense that some of our guests may have spent some time afterwards trying their luck on the casino floor and I heard tell of a few drinks being enjoyed at the B Bar. But I wouldn't know anything about that!

Thursday Morning

After breakfast on Thursday Past President, Brian Herdman, presented Chapter Awards to members who had achieved Founders Awards (see Fall 2023 issue, p. 40 for a complete listing), then concluded by presenting the Chapter President's Award to Fatimah Muhammad and the Member in a Non-Leadership Position to Hanna Hartnett for their exceptional support of the Chapter's initiatives over the past year. Brian then performed the installation of Officers and Board Members for the current Chapter Year.

Mike McKeever, event emcee, then introduced Dr. Ronal Hirsch, a familiar face to Institute attendees, who spoke about bridging the gap between revenue cycle and case management. He stressed the importance of proactive financial review and counseling, in that it can avoid downstream disruption of revenue flow. He also mentioned that the Two Midnight Rule has been in place for 10 years now, and how Medicare continues to evolve. And as there in not a national benchmark

observation rate, it's important to follow Hirsch's Law to ensure proper payment. Dr. Hirsch also included in his discussion issues related to Advantage Plans, the importance of clinical support for all diagnoses, the value of reviewing the PEPPER Report, and the need to perform ongoing charge description master maintenance.

Dr. Hirsch was followed by another speaker familiar to Institute attendees, as Day Egusquiza discussed the impact of Medicaid re-enrollment in markets across the country. Her proposed mission statement for the revenue cycle staff incudes that the patient didn't choose to be sick, the patient did not ask to have their life disrupted, the patient did not choose to have their insurance pay so little, if anything at all, and that the patient is scared and doesn't know where to turn to navigate the business of healthcare. Day went on to say that keeping these principles in mind, providers need to establish a robust program that incorporates Patient Financial Navigators as an essential part of the revenue cycle team.

Keynote Address

Bob Garrett was originally scheduled to provide the keynote presentation at the 47th Annual Institute but was unable to participate due to a request from the Governor's Office for him to attend another function, so Regina Foley, the Chief Transformation Officer and Chief Nursing Officer for Hackensack Meridian Health presented in his absence, although Bob did record a video message that was played before her presentation. Regina explained to the audience who Hackensack Meridian Health was and presented a timeline of the system's growth and expansion. She went on to explain how the system viewed the pandemic, and the lessons learned, as an impetus to reimagine Hackensack Meridian Health. She defined the guiding principles driving this process, with the end result of over $1.3 billion in savings and cost avoidance realized over the past three years. Finally, she elaborated on the focus areas that will continue to shape the future of the system. After her presentation an attendee came up to me and said that in their opinion Regina was truly a "Jersey Girl". I don't think there has ever been higher praise given to one of our presenters.

Thursday Afternoon

After the lunch break attendees once again had a variety of breakout session to choose from, including presentations focusing on workforce management, enterprise privacy and security, merger and acquisition activity, payer contracts, Healthcare hot topics, federal and state fraud and abuse investigations, aligning clinical and financial data, improving the bottom line through clinical knowledge, the conclusion of the Public Health Emergency, compliance and revenue integrity coordination, and using analytics to transition to value-based care. And during the afternoon break was the ever-popular ice cream social, where attendees could enjoy a tasty treat to provide the energy needed to make it through the rest of the day and the networking events to come.

Thursday afternoon ended with a new addition to the agenda, the Revenue Cycle Roundtable. Moderated by Maria Facciponti from Affiliated healthcare Management and President-Elect of the New Jersey Chapter, the panelist included Sandy Gubbine from AtlantiCare, Joe Scargle from RWJ Barnabas Health, Steven Honeywell from Penn Medicine, Anne Goodwill-Pritchett from Hackensack Meridian Health, and Christy Pehanich from Geisinger Health System. Being leaders in their field, the panelists discussed those issues that strongly affect their individual systems, and some of the solutions they've implemented to mitigate these factors. They also discussed staffing, which is still on everyone's mind as we adjust to the new post-pandemic world.

Thursday Evening

The President's Reception this year was held at the Borgata Indoor Pool & Gardens. It's been a few years since we've used this space, and the guests seemed to enjoy the elegance of the surroundings, starting with the long double staircase leading to the pool area. And of course, there were the shrimp. It just wouldn't be the President's Reception without Borgata's jumbo shrimp appetizer, which this year was teamed with an assortment of passed hors d'oeuvres and food stations. Attendees mingled while enjoying the bounteous spread and fine selection of cocktails, while enjoying the sounds of a jazz trio in the background.

The Thursday Late-Night Dance Party has traditionally been held at the Premier Nightclub, but due to scheduling issues this space was not available this year. When the committee first became aware of this, there was concern, as the other spaces recommended didn't seem appropriate for our gathering. But there was a new space in the recently renamed MGM Tower that we visited, and with a little imagination it fit the bill quite nicely. The Water Club used to have an indoor pool on the 32nd floor, but the pool has been removed and the space is now available for multi-purpose use. For the late-night event a dance floor was installed, portable bars and tables were brought in, and a sound system and lighting package was added to give what was when we initially saw it just an open space a true nightclub feel. And of course, the one wall was floor to ceiling glass, providing a striking panoramic view of the Atlantic City. Once the music started and the dance floor filled the attendees forgot all about the Premier.

Friday's Finale

Friday morning's first session was a panel focusing on Patient Financing. Jeffrey Hinkle from Lehigh Valley Health Network, Dennis Jones from Jefferson Health, Sheldon Pink, a Revenue Cycle Executive and John Fistner from Able Pay discussed the effects the Social Determinants of Health had on patient financing, in that the patient in many ways has become the new payer. Creative patient financing helps relieve the direct debt from the patient, who often does not fully understand their applicable co-pays and deductibles. The difference between recourse versus non-recourse debt was explained, as were the effects of recent legislation.

The second Friday session was presented by Deborah Visconi, President and CEO, and Barbara Piascik, Chief Compliance Officer, for Bergen New Bridge Medical Center. In explaining Bergen New Bridge's journey to achieve greater diversity, equity and inclusion they pointed out that the recent pandemic truly shined a light on the disparities inherent in our current system. They discussed the recent update to the Joint Commission Standards aimed at reducing these disparities, as well as the updated CMS framework to advance equity, expand access and improve outcomes for all beneficiaries of federal programs. But in the end, it is the right thing to do.

CFOs Panel

The last educational session on the agenda was the CFO Panel. This year the panel was moderated by Michael Galloway, from EnableComp, and included as panelists Bob Segin from Virtua Health System, Spencer Kowal from Geisinger Health System, Leigh Ehrlich from Lehigh Valley Health Network and Michael Tretina from Bayhealth Medical Center. Even though the Public Health Emergency has ended, providers continue to struggle with increasing costs, workforce issues, financial performance and anemic margins. Also discussed were payer issues, such as the transition to value-based care, mergers and acquisitions, and rising interest rates on borrowing. The attendees seemed appreciative of the panelists' insights into these areas of concern to us all.

And Next Year…

After the last panel, and the raffle drawing whereby a lucky attendee won a $250 gift card, the 47th Annual Institute came to a close. But the last announcement of the day contained big news. The 2024 Annual Institute will be held on October 9 – 11, 2024, at the Hard Rock Hotel & Casino on the Atlantic City Boardwalk. Don't forget to mark your calendars, because you don't want to miss our first Institute at this exciting new venue!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Revenue Cycle Interview with Susan Klein and Kaitlyn Senatra

Fatimah Muhammad

Denny Henderson

by Fatimah Muhammed and Denny Henderson

Revenue Cycle operations in a hospital encompass a wide range of processes and systems that ensure the financial stability of the healthcare organization. Traditionally, managing the revenue cycle has been the responsibility of finance and administrative departments. However, there is a growing trend where nurses are taking on leadership roles in revenue cycle management, with a particular focus on managing denials and driving cost savings.

Nurses bring a unique perspective and understanding of patient care and clinical documentation, making them valuable contributors to the revenue cycle process. By leveraging their clinical expertise, nurses can identify areas for improvement in documentation practices, minimize denials, and ensure accurate and complete billing.

Managing denials is a critical aspect of revenue cycle management. Denials occur when insurance companies reject or refuse to pay for services provided to patients, which leads to significant financial losses for hospitals if not effectively managed. Nurses, with their clinical knowledge, play a vital role in identifying and addressing the root causes of clinical denials. They collaborate closely with physicians, coders, and other stakeholders to ensure proper documentation and appropriate coding, thereby reducing the likelihood of a clinical denial.

Additionally, nurses also play a key role in stewardship, which involves responsible resource utilization and cost containment. By establishing denials management teams and providing training, nurses can educate their colleagues on best practices for documentation, coding, and billing. They offer ongoing support and guidance to ensure compliance with regulatory requirements and optimize revenue generation. Through their leadership, nurses can contribute to significant cost savings for the hospital while maintaining high-quality patient care.

The involvement of nurses in leadership roles within revenue cycle management, specifically in managing clinical denials and promoting stewardship, can have a profound impact on a hospital's financial health. Their clinical expertise, combined with an understanding of revenue cycle operations, enables them to identify areas for improvement, train denials management teams, and ultimately save money for the organization.

Moreover, it is crucial to acknowledge the significance of having leaders, educators, and team builders like Susan Klein, whom I had the pleasure of interviewing, in the field of revenue cycle. Her experiences, expertise, and impact on revenue cycle management as they pertain to clinical denials, as demonstrated in her career at institutions like Saint Peter's University Hospital, are invaluable.

New professionals entering the revenue cycle field, such as Kaitlyn Senetra, can greatly benefit from the guidance and insights provided by these leaders. Susan Klein, an experienced nurse, and one of the revenue cycle leaders for clinical denials at Saint Peter's University Hospital, has embarked on a remarkable journey in the healthcare industry. With her extensive clinical expertise and passion for optimizing financial operations, Susan has made significant contributions to the hospital's revenue cycle management pertaining to the clinical side of revenue cycle operations.

As an accomplished nurse, Susan understands the intricate connection between quality patient care and effective revenue cycle processes. Throughout her career, she has witnessed firsthand the impact that denied claims can have on a hospital's bottom line. Determined to address this challenge, Susan uses clinical expertise and knowledge of inpatient prospective payment systems, ultimately becoming one of the revenue cycle leaders addressing clinical denials for maximizing revenue and minimizing financial losses.

Susan's journey in healthcare began with working in the financial sector of hospital operations. Recognizing that often clinical documentation did not support medical necessity for inpatient admissions and identification of diagnoses that impacted severity of illness, Susan obtained her nursing degree (RN) then an MSN in Nursing Informatics. Her experiences as a nurse specializing in improving clinical documentation while improving the financial stability of the hospital revenue cycle lead her to become a specialist into the complex world of revenue cycle management. Susan is one of the leaders and advocates for collaboration and innovation within the revenue cycle department.

At Saint Peter's University Hospital, Susan has successfully led initiatives to identify and address the root causes of clinical denials. By leveraging her clinical knowledge and fostering strong relationships with physicians, coders, and other stakeholders, she has implemented strategies ensuring accurate and complete documentation. Through targeted training programs and ongoing support, Susan has engaged her staff and colleagues to optimize clinical documentation integrity needed for optimal coding practices to minimize denials.

In her interview, Susan Klein will share her insights and experiences as a nurse-turned-revenue cycle leader for clinical denials. She will shed light on the challenges faced in managing denials and the innovative approaches she has employed to overcome them. Susan's journey is a testament to the invaluable role nurses can play in revenue cycle optimization and their ability to bridge the gap between patient care and financial stability.

Join us as we dive into Susan Klein's inspiring journey and gain valuable insights into the critical intersection of nursing and revenue cycle management,and Kaitlyn Senatra, a recent graduate, as well as an early careerist in revenue cycle at Saint Peter's University Hospital.

Fatimah: Good morning, Susan and Kaitlyn. Thank you so much for agreeing to do this. We want to get insight for our readers to see what it's like for people who are pursuing a revenue cycle career, learning about their journey, and how they deal with the role they have related to the revenue cycle. Susan, I would love for you to tell us a little about yourself and your journey, and how you landed in your current role as a hospital revenue cycle leader.

Susan: I really started working in a hospital when I was twenty years old as a clerk analyzing emergency room records for the CDC. I worked my way up from ER correspondence to Director, and there is basically not a position in Health Information that I did not work in somewhere, shape, or form. My expertise is marrying the clinical with the business, improving clinical documentation for compliant billing. The revenue cycle has two sides, the side that I am on which is the clinical side, including coding and CDI (Clinical Documentation Integrity), and the other side is patient accounts that do the actual billing. My side determines what is going to be billed (diagnoses, procedures) and their side does the actual billing. Going back to my history, the hospital I worked in at the time was before the actual DRG system started. This hospital was one of the beta sites in the United States for the DRG system. I was on the ground floor and worked in the department with the coding and DRG piece, so I can honestly say that I've been there since its birth. I stayed in that position of DRG manager for a while, and the Director, Health Information Management in two places. Before becoming a director, I decided I've always loved the clinical side and decided to go for my nursing degree. I worked in health information while going to school for my nursing degree and after obtaining clinical experience, I went back into the business part of it. I was a healthcare consultant for a few years, actually working in NY/NJ hospitals, auditing records to improve coding and DRG assignments, and basically finding revenue that was not captured due to coding errors. This was a very successful road to the position I am in now and enabled me to see all the different problems various organizations have. I left consulting, truthfully because the drive over the George Washington Bridge was just terrible, and went back into the hospital organization and using my expertise I started working as a DRG manager and ultimately became the director. When I was a DRG manager, we hired a company that was one of the first to have expertise in CDI programs and I became very involved in that. I took the experience I gained and designed my own program based on my experience as a DRG/coding manager and working with major hospitals in NYC. This experience gave me the ability to see where the errors are, how people think and how they make mistakes, where mistakes happen in DRG assignments, etc. The hospital I was working in was going to go bankrupt due to issues between physicians leaving the organization, and I was approached by the administrators at Saint Peter's to join the organization 16 years ago to start a CDI program. I did not have an intention to leave the facility I was in because of the commute, but I walked around and thought it was a really fantastic organization based on interactions with senior administrators and the employees, and was hired on the spot. I decided to join Saint Peter's to implement my own CDI program which is what I've always wanted to do. I started by myself, knew all the areas that needed major changes, and the administration was extremely happy with the program. Eventually I gained Clinical Documentation nursing staff (CDS), then leadership put coding under me. I moved coding onto patient units to concurrently code and partnered each

coder with a CDS RN. This partnership joined the technical (coding) with clinical (nursing) which was extremely successful for improving the revenue cycle. Saint Peter's was one of the first hospitals to develop concurrent coding. Additionally, we integrated coding with the various nursing metrics for quality reporting and were able to participate in receiving our Five-Star ratings, and that's where we are today. As far as the revenue cycle goes, coding and clinical documentation has really evolved into being the main focus for payer denials pertaining to medical necessity admission and DRG downgrades. It is a process that's constantly evolving because payers change their guidelines, and we need to be knowledgeable about those changes. Saint Peter's also outsources a percentage of our denials and manages a percentage internally, and I have trained staff to write appeals. It is a never-ending task that my area handles on the inpatient denial side.

Fatimah: Wow that is very impressive Susan. The journey, the implementations, a lot of informatics and clinicians can learn from you considering you were there before a lot of these programs were up and running. Could you give us an example of a challenging situation you faced in revenue cycle management and how you successfully resolved it?

Susan: It's hard to say which are the biggest issues with the revenue cycle, but an example is denials. We appeal, we establish clinical guidelines working in tandem with medical leadership, and we win those appeals, but it's a constant struggle. The payers are always fighting it, and we have to appeal their determinations. Before, coders coded on discharge, and the discharges took anywhere from 3-5 days to final code for billing, and a lot of the time those periods exceeded five days. Sometimes the documentation is not supportive of a particular DRG or what you are trying to code because documentation is not consistent within the chart. So, the implementation of concurrent coding was my resolution to this challenge, because a chart is looked at by a coder and a CDS either every day or every few days, and if the coder comes up with an issue or problem during the concurrent review they have the CDS partner to assist them and be the liaison between coder and physician. The documentation is improved by the health provider which then supports an accurate DRG assignment. You have a) documentation is pristine and supports what is being coded and b) by the time the patient is discharged the bulk of admissions are able to be final coded and billed by patient accounts. I would say that was one of the challenges to solve.

Fatimah: So how do you prioritize tasks and manage competing demands in a fast-paced healthcare environment?

Susan: First, you have to train your staff to be skilled and autonomous, and when your staff is strong and well trained, then you are managing at a higher level. One of the things my coders loved is being on the patient unit, I consider them managers of themselves. They don't have a supervisor hanging over every second of the day when they are in a room trying to figure out documentation by themselves. The coders are able to really manage themselves and they are independent. The coders and clinical documentation specialists have been with me for a long time, so I'm lucky my staff very rarely leaves. I'm able to keep my staff because I try to make the environment a good place for staff to work. We are a level 1 with staff satisfaction, so that's how I'm able to juggle many tasks because my staff can handle a lot without my having to look over every detail. I had to in the beginning, but now I have a very strong coding supervisor who is awesome and she went and received her clinical documentation specialist credential, and although she is not a nurse her documentation skills are above and beyond your average coding supervisor. She's been with me for quite some time now and is able to pick up errors on the documentation side as well. So that's how I'm able to manage the demands of this role.

Fatimah: That is pretty amazing. I really appreciate how you reflected on your past and knew what you wanted to implement, to have a staff not only appreciate your leadership but want to become stronger in being able to do the job and possess the skills. So, what metrics do you use to measure the success of the revenue cycle operations that you work in and how do you analyze and interpret these metrics to drive improvements?

Susan: One of the indicators most organizations look at is the case mix index or the CMI, and the CMI is representative of severity of illness and has a basis in coding and clinical documentation. So we look at that constantly; in fact we use a report that comes out three times a day and has every single patient on the inpatient units, and has patient name, unit, admission/discharge dates, age, insurance, the DRG, the relative weight of the DRG, and the reimbursement attached to that DRG. This report is disseminated through nursing, leadership, and myself and I review it each day. I also have oversight on the financial side of operations with Care Coordination and we use DRGs for length of stay metrics. Those metrics are always looked at for analyzing severity of illness in conjunction with length of stay (LOS) and the case mix index, and then we also look at compliance audits. We would love to look at the percentage of CCs and MCCs, but don't have a reporting mechanism, however, because we do a lot of auditing concurrently and using this report, we meet with the staff twice a week to go over each case and I give direction using my clinical skills. That is basically how we look at the metrics. Ideally there is software that could spit out these metrics easily, but we don't have this tool so we do the best with what we have to work with.

Fatimah: That's pretty impressive considering you're on top of it and do meet with your team to ensure that they are on top of what they do and given that you don't possess the technology that you desire and you have a strong team doing the best that they can. Dealing with Care Coordination and dealing with an array of different nurses, social workers and different departments, what have you learned coordinating with other departments and how has it changed your perspective?

Susan: Care Coordination is an incredible department and really encompasses everything from a patient care perspective. I believe the finance portion of Care Coordination was given to me so that the director could handle the clinical piece, as she is a social worker by training and honestly, I would call her one of the best directors of social workers that I have ever experienced so we are very fortunate to have her. Looking at the nurses and social workers, we are getting involved with social determinants of health, discharge planning, how we work in tandem with the physicians on the clinical side getting these patients and identifying a good discharge plan, and just seeing the challenges that they are able to overcome with minimal staffing. And staffing is always an issue, in fact we are dealing with understaffing now and our staff to the best of their abilities rise to the occasion. On the flip side we could strive to improve length of stay and forecasting length of stay, and we are now engaging clinical documentation specialists to also look at length of stay – real time, and that's a work in progress. So, there is a huge amount of work managing complex patients, and New Jersey is a sanctuary state, so we have a lot of patients without insurance. Trying to develop a good discharge plan is often a complicated undertaking. That really opened my eyes to see our patient population and trying to manage from a business perspective how we can do better to turn things around, and on my end, it would be length of stay. It's not the most optimal to manage LOS with DRG's because the CMS DRG LOS, is very low. You get patients that are incredibly sick and have had minimal to no primary care and by the time they get to the hospital they are very ill and there is no place to discharge them if they don't have a payer source. So that's really a work in progress all the time, managing these patients and working on providing support for them and looking at expediting LOS and continued stay so that's where we are at right now and how we manage those with the revenue cycle.

Fatimah: So, Susan, for the role you have and just listening to how you operate, you're very engaged. So, what gets you engaged or motivated to go beyond expectations?

Susan: I love it. I would have to say those three words, I. Love. It. I have a passion for this role and this career, it challenges me every single day. The position is never one where you say okay, I'm bored now where is my next hill to climb? There's always a hill to climb, always processes that need to be tweaked. Like right now, we have identified issues with our UR process because we don't have enough staff, and it leads to denials and impacts the revenue cycle. So, we are in the process of analyzing and getting ready to restructure the UR process so that we improve and mitigate the percentage of denials we receive. I think part of it is the holistic way we approach the continuum from the time the patient comes to the hospital, the coordination of staff, concurrent coding, clinical documentation, care coordination, working with the physicians, and our excellent physician advisors. Some of the best I have had the privilege to work with. So, it is a really good team and it keeps my interest every day and I find it fun.

Fatimah: And you know to be great at what we do, you must enjoy it. So, you mentioned denials, would you say that denials are a significant challenge in a typical day that takes the most time to address with your role or your team's role?

Susan: I wouldn't say it takes the majority, but it does take a good chunk, maybe like 50% of my day.

Fatimah: So, what would you say takes the most time or what kind of challenge takes up the most time?

Susan: I would have to say it's a combination of establishing medical necessity and improving clinical documentation. Those two roles are very intertwined, so I would consider them almost 100% because if the clinical documentation does not support what you are billing, then you will get a denial. If you don't respond to payers' requests in a timely manner you will receive denials and risk losing revenue. A lot of hospitals consider 10% of denials as the cost of doing business, and they might not appeal those. We appeal everything if it's legitimate. I don't believe in "okay let's be happy with a percentage, and we won't bother" no; if we feel that we were correct we will appeal it. My job is really a whole continuum as a circle that equals 100%, so each one has to be addressed and monitored and if you don't, you won't be on top of your operations.

Fatimah: And that is what sets you apart from many and why you are considered an expert in that role. And I'm sure this requires a huge amount of communication, so how do you ensure effective communication and collaboration between revenue cycle leaders and management to align goals and strategies?

Susan: Well first, our leadership is on point with looking at denials and operations that need to be improved to mitigate those denials. We have a strong Patient Financial Services Director and team and we have constant meetings and we work collaboratively with the Director of Managed Care who assists

handling problems we might have with payers. So it's making sure communication stays open. We all get along well, and our goal is to make Saint Peter's the most effective facility we can, operational wise. So, each person has their own expertise and when we meet, which is monthly, with different committees addressing different issues, we bring them to the table. And I would have to say its constant emails, picking up the phone, monthly denials meetings, we are getting ready to do a denials management meeting where we look at identification and strategies to further mitigate. So, it's always a work in progress and that's how we get it done. You must eliminate the silos. There were silos in the beginning, but slowly but surely we are removing those silos. For example, with Managed Care, I need to know what the contracts say for readmissions, and what they allow or don't allow. I need to manage operations in point with the payers, because if you are not managing your operations with the payers' requirements, you will get denials. So that's the reason why those three areas, patient accounts, myself, and managed care routinely meet.

Fatimah: So, Susan, what would you say are some of the future trends or challenges you anticipate in revenue cycle management and how do you plan to address them?

Susan: I would say managing payer denials. There's going to be two issues: payer denials and length of stay management. If your length of stay exceeds the suggested number of days you'll begin to lose revenue. So, LOS management is a huge piece of it because when you lose revenue that's money down the drain. So, I would say that is number one, and number two is the clinical documentation supporting that admission. Both are essential to managing operations to mitigate payer denials. So, there's so many different aspects to payer denials and you have to manage each area individually, so you don't give them an excuse to just not pay. Every area on both sides, on the Care Coordination side, on the CDI and coding side, and on the Patient Account side. These are the major issues. Looking at LOS, having enough staff to efficiently manage, improving relationships with physicians, which we couldn't have a better relationship with because of our medical teaching service, which is a huge chunk of our admissions, and we have what we call the non-medical teaching hospital service with Saint Peter's which is the other bulk of it. These two services are very supportive. So, when you have that close relationship that you develop and everyone feels comfortable and can communicate problems and issues, medical leadership has buy-in. We have buy-in in almost every area, especially now when denials are going up, that forces us to look at where the ball is being dropped because there is always an area that can be improved. So that's where we are at right now and that's the future.

Fatimah: Susan, I would love to know, and our readers would also love to know, and this is one thing I'm excited about as well because we have Kaitlyn Senetre who is a recent intern and HFMA member here, and she had the opportunity and privilege to shadow you for a few months this year. If you could give a piece of career advice, what would it be?

Susan: If you're going to work in a hospital, most areas have specific requirements. So, on the clinical side it would be difficult for an individual that's not clinical to understand the various aspects. So, if you're going to be in the revenue cycle you really need to make it your business to learn every aspect of that revenue cycle. Even if you're not completely knowledgeable about particular areas, you don't need to be, but you do need to know what it takes – it takes collaboration with your colleagues who do have expertise in various areas. It's like baking a cake, maybe you're not a baker and only going to do a one-layer cake at a simplistic level, but you do understand the ingredients that go into baking that cake, and the revenue cycle is the same. So, you need to get experience and just understand what a DRG is, maybe shadowing for a month in Care Coordination Department and looking at their discharge process. Being in meetings with physicians and leadership and to hear the issues and problems and how we are solving them. I did not become an expert in my field because I was born that way. I have a naturally inquisitive nature; I ask questions and I make it my business to learn. And that's what I would have to say if you want to be successful you must have an inquisitive nature and you need to ask questions and take it upon yourself to learn it. Even in your own time, you could take a personal day and attend outside meetings, and people are usually kind and know you're trying to learn, and they will help you. That's what I would say is the biggest thing, learning each aspect. You don't need to be an expert, but you need to know what goes into this career to have an understanding.

Fatimah: That's amazing. What's the saying, you are a jack of all trades but a master of none… something like that. And that's very true and good to know when you are coming up in the ranks. So, Kaitlyn, you're a new graduate, you got to shadow Susan's role, share with us what that was like for you and your thoughts about going into the revenue cycle. Looking at it from your lens and embarking on this journey, please just give a quick overview of your thoughts before you got into it, what it was like shadowing Susan and the role you imagine yourself being in and how you feel about it now.

Kaitlyn: Before I met Susan or started shadowing with her, I was trying to figure out my path as a new graduate in the healthcare industry. There are so many different areas to explore, and I felt very fortunate to gain insight into the revenue

cycle career and how it is run at Saint Peter's. Once I did start working with Susan, I was extremely fascinated by the day-to-day operations. I was able to shadow different staff members in her team and how each individual member has their own unique role, and how they all work together for the same goal. I believe that the revenue cycle is essential to ensuring our healthcare providers can deliver quality care and would love to be a part of that team someday. As I continue to learn, like Susan said you need to be constantly learning, I hope that I will find my place in this journey of becoming a healthcare leader.

Fatimah: Lovely. Well Susan, I must say I have heard nothing but good things about everything you do and you're like a wizard in this niche of dealing with DRGs and revenue cycle. And there is so much more that we can learn, and I really appreciate you taking the time today and cannot wait for you to see the outcome.

Susan: Thank you so much Fatimah, and well said Kaitlyn, because the hospitals can't survive without the behind-the-scenes staff dealing with all the other aspects, and if you don't have a well-run revenue cycle you don't have a hospital. Like I said when I was consulting, I was called to go into hospitals because they were starting to lose a lot of money, and that's the first place you look, coding and clinical documentation and areas of the revenue cycle. I am on the clinical side and am fortunate to work with strong leaders in managed care, patient accounts, and my area. So that's really what makes a hospital shine. The better the hospital operations, the better care we can give to patients and the community we serve.

Fatimah: I second that, and could not have said it better.

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•Focus on...New Jobs in New Jersey•

JOB BANK SUMMARY LISTING

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

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Job Position and Organization

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Hackensack Meridian Health - HMH HOSPITALS CORP

MANAGER, REVENUE INTEGRITY
AtlantiCare

DIRECTOR, UTILIZATION MANAGEMENT & REVENUE INTEGRITY
AtlantiCare

Certification Corner: Congratulations Are in Order!

It is with great pleasure and pride that we extend our heartfelt congratulations to a group of outstanding individuals who have recently achieved the prestigious HFMA certification. This remarkable accomplishment highlights their dedication to professional development and their commitment to excellence.
Their pursuit of excellence serves as an inspiration to us all, reminding us of the importance of embracing opportunities for growth and development. As a community, let us join together in congratulating these individuals on their well-deserved accomplishments.

Certified Healthcare Financial Professional (CHFP)

Stephan Alcuino, CHFP	CareWell Health
Rosemary Bain, CHFP	ONSITE NEONATAL PARTNERS
Kevin Moyer, CSAF,CHFP	Sax LLP
Kathleen Noorigian, CHFP	The Valley Hospital

Certified Revenue Cycle Representative (CRCR)

Abuchi Afam, CRCR	Ensemble Health Partners
Johanna Aguilar, CRCR	Ensemble Health Partners
Michael Alwell, FHFMA, MPA,CRCR,CSPPM	St. Joseph's Health
Ghazanfar Bashir, CRCR,CSPPM	medSR
Gina Basile, CRCR	AtlantiCare Regional Medical Center
Antondre Bender, CRCR	J.P. Morgan Healthcare Payments
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Weston Cranford, CRCR	Ensemble Health Partners
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Dawn Earley, CRCR	Ensemble Health Partners
MaryRose Estrada, CRCR	HMH Pascack Valley Medical Center
Stephanie Ferris, CRCR	Bayada Home Health Care
Cynthia Gerkhardt, CRCR	Bayada Home Health Care
Bradley Gingerich, CRCR	Ensemble Health Partners
Diane Giovanniello, CRCR	
Maddie Gronske, CRCR,CSPR,CSBI	Bayada Home Health Care
Brian Holman, CRCR	Grant Thornton LLP
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Kevin Jones, CRCR	Bayada Home Health Care
Ivy Jones, CRCR	
Ashley Jones, CRCR	
Mahenoor Khan, CRCR	AtlantiCare Regional Medical Center
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Fatimah Muhammad, CRCR,CSPR	Saint Peter’s University Hospital
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Selenia Paulino, CRCR	
Matthew Pierre, CRCR,CSBI	Montefiore Health System
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Danielle Simmons, CRCR	Bayada Home Health Care
Claudia Small, CRCR	
Sharon Snellbaker, CRCR,CSPR	John Brooks Recovery Center - AtlantiCare
Jacid Soto, CRCR	The Valley Hospital
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Amina Razanica, MBA, FHFMA	New Jersey Hospital Association

Unraveling the Inflation Reduction Act: Examining the Impact on Healthcare Costs, Access, and Quality

Fatimah Muhammad

by Fatimah Muhammad

Over the years, inflation rates have been steadily increasing in various sectors, including healthcare. This has significantly impacted consumers, healthcare providers, and the overall economy. Rising costs of healthcare have made it difficult for individuals to afford necessary medical treatments and services, leading to financial strain and limited access to care.

The Inflation Reduction Act (IRA) was introduced as a response to the skyrocketing healthcare costs and the need to control inflation in the healthcare sector. Its primary objective is to implement measures that would help contain costs, promote cost transparency, and ensure affordable access to quality healthcare services for all individuals. The IRA recognizes the importance of addressing the root causes of inflation and implementing effective strategies to curb its effects.

Key Provisions of the Inflation Reduction Act:

Cost containment measures: The IRA outlines various strategies to control healthcare costs. One of the key measures is implementing price controls and regulations on pharmaceutical companies, medical providers, and insurance providers. These measures aim to limit excessive pricing and encourage greater cost transparency within the healthcare industry.

Price controls and regulations: The IRA includes specific mechanisms for price regulation, such as negotiating drug prices, limiting price increases, and setting ceiling prices for certain medical procedures. By implementing these price controls, the legislation aims to reduce the overall cost of healthcare and make it more affordable for individuals.

The Inflation Reduction Act (IRA) was introduced as a response to the skyrocketing healthcare costs and the need to control inflation in the healthcare sector. Its primary objective is to implement measures that would help contain costs, promote cost transparency, and ensure affordable access to quality healthcare services for all individuals.

Budget allocations and spending caps:

Another important provision of the IRA is the imposition of stricter budget control measures to restrict healthcare spending. This includes implementing spending caps, establishing oversight agencies to monitor spending, and imposing consequences for exceeding allocated budgets. These measures are designed to ensure that healthcare providers and payers operate within their approved budgets and contribute to overall cost-containment efforts.

Healthcare reimbursement reforms:

The IRA also introduces changes to healthcare reim-bursement models to align financial incentives with value-based care. The shift towards value-based payment models aims to reward healthcare providers based on quality outcomes and cost savings, rather than solely on the volume of services provided.

Value-based payment models:

The IRA incentivizes the adoption of value-based payment models, such as pay-for-performance and accountable care organizations. These models encourage healthcare providers to focus on delivering high-quality care and improving patient outcomes. By linking reimbursement to performance, the IRA seeks to promote efficient and effective healthcare delivery while reducing costs.

Bundled payments and shared savings programs:

The IRA also promotes bundled payments and shared savings programs to incentivize coordination and efficiency among healthcare providers. These payment models encourage collabo-

ration and reduce fragmentation in the healthcare system, leading to better care coordination and potentially lower costs.

Impact on healthcare providers and payers:

The IRA's cost containment measures may present challenges and opportunities for healthcare providers and payers. Providers may need to adapt their pricing structures and operational strategies to comply with the new regulations. Similarly, insurers may face the need to adjust their coverage offerings to remain financially viable. However, these changes have the potential to ensure more affordable healthcare options for individuals and greater financial stability for providers.

Effects on patients and access to care:

The IRA's cost containment measures can have significant implications for patients' access to care and affordability. While the IRA aims to make healthcare more affordable, there is a need to ensure that it does not result in reduced access or limitations in accessing necessary treatments. Ongoing monitoring and evaluation of the IRA's impact on patient access to care will be crucial to address any potential issues.

Quality improvement initiatives:

The emphasis on value-based care in the IRA has broader implications for quality improvement, preventive care, and population health. By promoting value-based payment models, the IRA encourages healthcare providers to focus on quality improvement initiatives. This can lead to better patient outcomes, reduced medical errors, and improved overall healthcare delivery. The emphasis on quality of care can potentially drive improvements in the healthcare system as a whole.

Increased focus on preventive care and population health:

The IRA's promotion of value-based care also encourages healthcare providers and payers to prioritize preventive care and population health management. By incentivizing these aspects of healthcare, this shift in focus could have significant positive impacts on the overall efforts of public health.

Challenges and Criticisms of the Inflation Reduction Act and potential limitations and unintended consequences:

Criticism of the IRA raises significant challenges and potential limitations regarding unintended consequences. One key concern is that the IRA's emphasis on reducing inflation may lead to cost-cutting measures in the healthcare sector, potentially compromising the quality and accessibility of care. Critics argue that reducing government spending on healthcare programs or constraining reimbursement rates could result in reduced services, longer wait times, and even hinder medical advancements. Moreover, there are worries that healthcare providers may respond by passing on additional costs to patients through higher fees or insurance premiums. This could disproportionately affect vulnerable populations, such as the uninsured or those with limited financial resources. Additionally, unintended consequences such as disruptions to healthcare supply chains or workforce shortages could emerge due to the financial constraints imposed by the legislation. Therefore, it is essential to carefully assess and mitigate these potential limitations and unintended consequences to ensure that healthcare remains affordable, accessible, and of high quality for all individuals, even in the face of inflation reduction efforts.

About the author

Fatimah Muhammad 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.

How Healthcare Organizations Can Prepare following the End of the PHE

Michael Newell

Richard Riter

Melaney Scott

by Michael Newell, Richard Riter, and Melaney Scott, CIA, CHC

The COVID-19 pandemic public health emergency (PHE) expired on May 11, 2023 — more than three years after it was first declared. Some PHE changes, like COVID-19 vaccine access, will remain. Others, like Medicaid continuous enrollment, will fade away. The potential impact of multiple revenue and compliance implications, covering everything from coding and billing to a shifting payer mix, should therefore be considered.

Hospitals will need to reassess nearly every business function for potential impacts, and healthcare leaders will need to break through silos and engage with trusted partners to mitigate risk and manage disruptions as they navigate change. Below are some areas where healthcare organizations can expect to see impacts and some steps to follow in preparation.

Medicaid Redetermination

Medicaid redeterminations have resumed with the ending of continuous enrollment. The federal payments that were incentivizing continuous state enrollment are phasing out through the end of 2023, starting with the 6.2% Federal Medical Assistance Percentage (FMAP). Medicaid populations in some states may lose coverage before others, like Florida, where roughly 250,000 people — many of them children — have already been terminated from their health plans.

While hospitals are likely to have prepared for more obvious revenue, reimbursement, and human impacts, some potential consequences may be less anticipated.

Employer Health Insurance

Some organizations may assume that when patients move from Medicaid to commercial employer-sponsored plans, hospital revenue will inevitably benefit, which could prove false if people move to plans with more expensive cost-sharing.

While the expected migration of 9.5 million people from Medicaid to employer health insurance on a claim-by-claim basis could seem like a potentially positive outcome, this would only apply when insurance is not only paying, but paying at a higher rate than Medicaid after factoring in uncollectible patient liabilities. Increasing numbers of self-pay patients could also lead to an increasing number of patients delaying care.

Less favorable instances could include people on employer or exchange plans with such high deductibles, coinsurance, and copayments that health care services would essentially become self-pay. Some patients may be unenrolled for administrative reasons, while still meeting Medicaid criteria.

It is incumbent on providers to not only educate patients about the redetermination process, but also to proactively engage with those being disenrolled to remedy enrollment issues before they seek care and prevent them from delaying care because they believe they are no longer covered.

Drug Pricing Program (340B) or Disproportionate Share Hospital Program (DSH)

As patients fall off Medicaid rolls, the result can potentially skew an organization's DSH calculations, perhaps making pre-

viously eligible hospitals become ineligible for both the 340B and DSH. This, of course, would also impact a hospital's distribution from the uncompensated care pool. These and other warnings exemplify the risks of making decisions in a silo.

As you plan your post-redetermination path, engage departments across the entire organization to assess impacts and lessen surprises. One team's change may affect another's, so alignment is critical.

Operational, Training, and Staffing Impacts

PHE changes are expected to have far-reaching operational impacts. The sprawling implications from redetermination to telehealth flexibilities and beyond require a reassessment of staffing, system configurations, and charge capture processes.

1135 Waivers

The US Department of Health and Human Services gave providers the flexibility to waive certain Medicare, Medicaid, Children's Health Insurance Program (CHIP), or HIPAA requirements, referred to as 1135 waivers, which will be expiring at various times as the PHE ends.

Health care providers may be subject to civil and administrative sanctions and penalties for noncompliance, so it is important to have a good tracking mechanism to outline varying 1135 waiver expirations and individuals actively monitoring the organization's progress as well as monitoring for changes or extensions.

Hospitals will need to reassess nearly every business function for potential impacts, and healthcare leaders will need to break through silos and engage with trusted partners to mitigate risk and manage disruptions as they navigate change.

Staffing Challenges

These and other challenges could leave provider staffing facing unpredictable difficulties. Consider what policies and procedures may need to be reviewed and updated to account for new processes—mainly, who will be doing this work and how they will be trained. Staff will need to be able to effectively perform these new processes. Training will be essential for workers to adapt to the additional wave of complexities from PHE.

Evolving Training Needs

Ongoing labor shortages could cause training hours to exceed what organizations can handle. For example, the flexibility that waived medical record request fulfillment timeliness requirements would revert to its original 30-day window. Health care providers will need to be appropriately staffed and trained to accommodate that change.

Medicaid redeterminations can have similar staffing and training impacts as hospitals work to identify those affected before getting overwhelmed with lost coverage cases. Patient-access staff, particularly financial counseling, could be greatly affected, considering that many patients will have just lost coverage. A lot of this staff will need retraining for their evolving roles.

Capacity Management to Address Labor Impacts

Appointing an individual in a full-time capacity management leadership role to oversee labor demands can help to provide structure in this area. A capacity management committee can also deliver value to prioritize work and commitment around key areas such as entry, care delivery, and discharge.

Impacts on Other Workflows

The end of the PHE coincides with other developments that affect workflows, including the good faith estimates (GFE) requirement for the No Surprises Act (NSA) and Centers for Medicare and Medicaid Services (CMS) Transmittal 18.

Additional operational focus areas persist, such as the need to improve revenue integrity and supply chains, and to reduce hospital-acquired infections. Concurrent activities may also be exacerbating revenue and compliance impacts that have already been impacted by the PHE. Beyond needing to adjust workflows in response to new developments, re-evaluating responses to past changes may also be in order, such as those addressed by the NSA.

Work queues created to support GFE-related compliance around some of the GFE components might not populate all the items as expected, leading to missed or improperly prepared items. Processes could have been rolled out across different departments at different times.

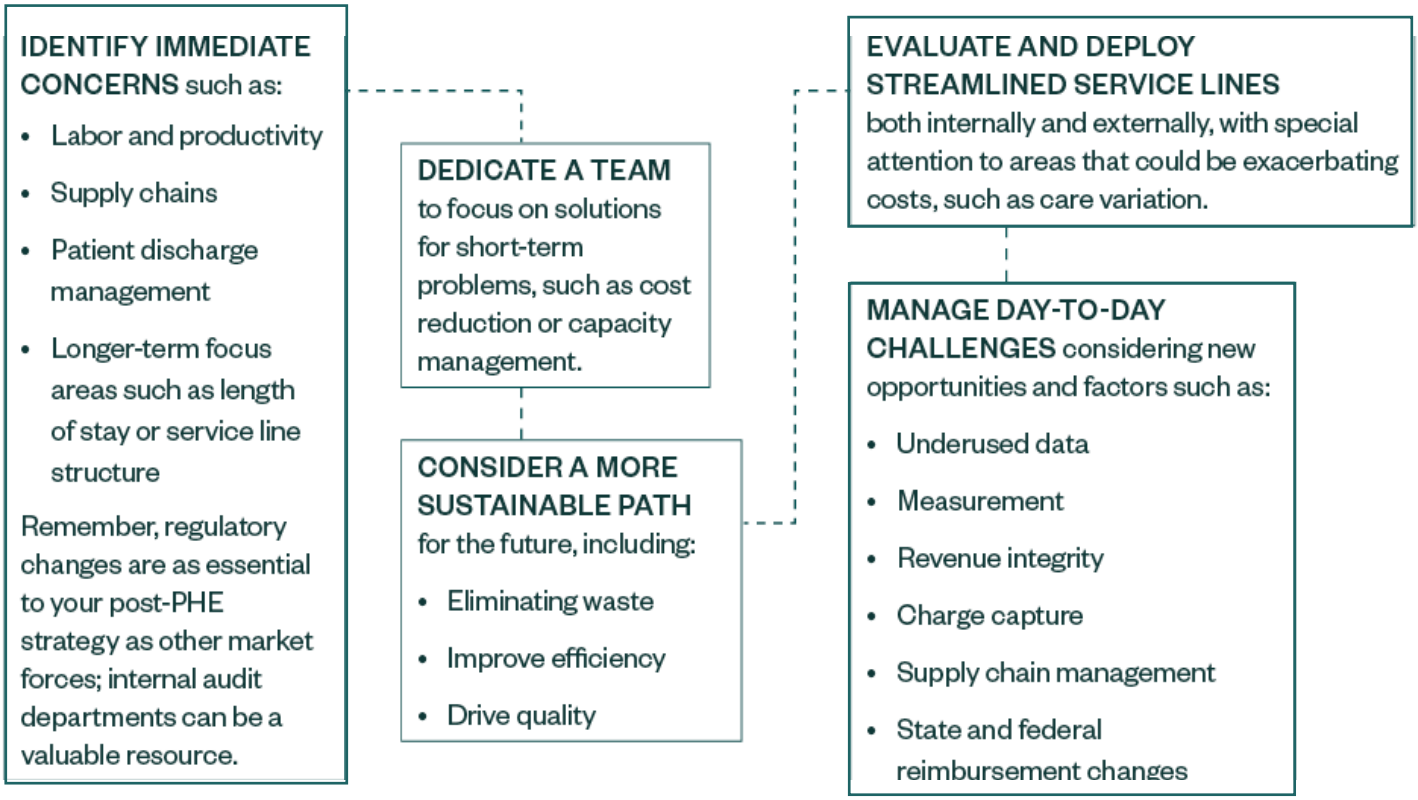
How to Prepare for Transitions

Healthcare leaders could benefit from taking a proactive and disciplined approach toward efficiency and cost-containment strategies, revenue maximization, and sustainable transformation. Consider this blueprint (see next page):

Conduct Thorough Assessments

Some waivers expired as soon as the PHE ended. Other waivers, like payment parity for telehealth services, will remain until the end of 2023. Still others, like Medicaid continuous enrollment, will fade out gradually on a state-by-state basis.

No matter where your organization falls in its readiness for



this road ahead, the complexity of this era will create challenges for even the most prepared healthcare systems — especially as they unfold concurrently with other major developments such as the NSA. With risks of domino effects, stay watchful for unexpected impacts and siloed reactions that can jeopardize operations.

Legislation is still ongoing, so an agile organization that's prepared to pivot as needed may be more able to adapt to circumstances such as changes slated for discontinuation ending up continued after all.

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What's Next in Healthcare Reimbursement

by Eric Lucas, Richard Riter, Melaney Scott, CIA, CHC, and Georgia Green, CHFP

Eric Lucas

Richard Riter

Melaney Scott

Georgia Green

The macroeconomic headwinds surrounding healthcare are changing, driving new dynamics and policy changes, and bringing significant impact to future reimbursement. For example, the Inflation Reduction Act has affected drug prices nationally. Additionally, regulations on healthcare transactions in Massachusetts, New York, Oregon, and California could also become a national trend.

As healthcare stakeholders navigate new developments, they face competing pressures, including the transition to value-based care (VBC), and market conditions such as labor shortages, wage growth, and cost control. Care delivery is changing as virtual care becomes embedded within the continuum – driving new questions and complexities as policies and payment models catch up.

Healthcare providers need to be aware of changes so they can be ready for the future of reimbursement. Two recent webcasts, available on demand, feature insights into an uncertain economic and policy landscape from representatives of the Centers for Medicare & Medicaid Services (CMS), the Center for Medicare & Medicaid Innovation (CMMI), and the Medicare Payment Advisory Commission (MedPAC).

Here are ways to prepare for the uncertain future of reimbursement:

- Effects of the Inflation Reduction Act
- Transition to value-based care
- The growth of Medicare Advantage
- Changes to Medicare physician fees
- Telehealth and virtual care
- What else we're watching

About the Webinars

Panel on the Future of Reimbursement Through the Lens of CMS:

Eric Lucas, Managing Director,
Healthcare Consulting Practice, Moss Adams
Susan Dentzer, CEO and President,
America's Physician Group
Elizabeth Fowler, JD, PhD, Deputy Administrator
and Director, CMMI
Meena Seshamani, MD, PhD, Deputy Administrator
and Director, CMS

Panel on the Future of Reimbursement Through the Lens of MedPAC:

Brian Conner, Partner, Healthcare Consulting
Practice, Moss Adams
Susan Dentzer, CEO and President,
America's Physician Groups
Michael Chernew, PhD, Chair, MedPAC
Eric Klein, Partner and Team Leader,
Sheppard Mullin National Healthcare Practice

Effects of the Inflation Reduction Act

The Inflation Reduction Act, passed in 2022, could create some risk exposure for health systems with its extensive reach. Healthcare stakeholders should be aware of its impacts. Pay attention to three provisions that could affect operations.

- Medicare can directly negotiate drug prices for certain high-expenditure, single-source drugs covered under either Parts B or D. CMS will publish the list of the first 10 Medicare drugs selected for that program (expected in September 2023), with the goal being to generate a maximum fair price – an upper limit for the negotiated price – for those drugs based on that negotiation process. Negotiated prices for the first 10 drugs will be available under this program in 2026.
- Pharmaceutical manufacturers must pay rebates if they raise prices faster than the rate of inflation. This change takes effect this year.
- The Part B inflation rebate manufacturers will now have to pay for certain single source drugs and biologicals with prices increasing faster than the inflation rate has implications for the 340B Drug Pricing Program.

To avoid a duplicate discount scenario, no later than January 1, 2024, CMS is requiring all 340B covered entities that submit claims for separately payable Part B drugs and biologicals to report modifier JG or TB on claim lines for drugs acquired through the 340B Drug Pricing Program. This is not new for hospitals paid under the Outpatient Prospective Payment System, but will be new for other covered entities participating in the 340B Drug Pricing Program.

Demonstrating CMMI's early influence on these policy changes, Elizabeth Fowler explained the Innovation Center was proud of the model they tested to offer Part D insulin at $35 – a model that would eventually inspire the provision in the Inflation Reduction Act. But there may be more to come – Ms. Fowler added that CMMI has submitted a paper to the White House outlining additional potential opportunities for transformation.

On the MedPAC side of things, Michael Chernew acknowledged the tension between the Inflation Reduction Act's cost control measures and the incentive to innovate. It's a potential concern of which all stakeholders should be aware and an issue that deserves ongoing discussion.

Key Takeaways

CMS has demonstrated a commitment to cutting drug costs, but the reimbursement squeeze will mostly affect the pharmaceutical industry. Health care providers should be aware of the changes, which will ultimately benefit patients, but rest assured at least for now, they're not in the immediate path of risk exposure.

Transition to Value-Based Care

By 2030, CMS aims to have roughly 30 million Medicare beneficiaries served by providers in accountable care relationships with CMS. But is that going to happen?

The January 2023 discussion on Future of Reimbursement with CMS featured panelists Elizabeth Fowler and Meena Seshamani who emphasized that the Medicare Shared Savings Program (MSSP) is the main focus of implementing CMS's strategic plan. Healthcare providers want and need feedback from all stakeholders.

Experts discussed positive gains as well as some learnings. For example, the number of Accountable Care Organizations (ACOs) in the MSSP declined from 483 in 2022 to 456 in 2023. That said, the number of Medicare beneficiaries served by these ACOs declined only slightly, from 11 million to 10.9 million, meaning that ACOs may be consolidating into larger groups and staying in the program, or that mostly small-sized ACOs are leaving the program.

While ACOs have provided care more efficiently, the savings are marginal – just 2–5%, which hasn't revolutionized spending in the fee-for-service (FFS) system.

One concern is rural providers are reluctant to assume the risk of a new payment model because they need stability and predictability, especially now. CMS acknowledged that strain, but suggested the need to resolve it so value-based care (VBC) prevails.

CMS efforts to remedy this strain include diversity, equity, and inclusion efforts such as health equity measures that reward providers serving disadvantaged groups. Panelists also discussed Advance Investment Payments. This is a concept tested by CMMI and then applied to MSSP, which involves giving money to new ACOs – up to $250,000 up front and $45 per member per quarter – to help them make value-based care financially feasible.

Some ACO experts appear excited about the Advance Investment Payments. During the pandemic many health care organizations deprioritized VBC strategies to focus on emergency response.

Now that the urgency of the COVID-19 pandemic has eased, many health systems and primary care provider networks are starting to reevaluate the MSSP, ACO Realizing Equity, Access, and Community Health (REACH), and commercial risk-based arrangements. This year is a strategic time for new ACOs to join the MSSP because of the Advance Investment Payments.

CMMI recently announced a new payment model dubbed Making Care Primary, which is being tested in eight states to encourage advanced primary care investments by Federally Qualified Health Centers (FQHCs), Tribal clinics, Method I Critical Access Hospitals, and solo and group primary care practices.

As mentioned above, applications of VBC extend beyond ACOs. Some suspect the industry will continue to see popula-

tion-based programs such as oncology bundles in the broader healthcare market. As reimbursement decreases, providers will turn toward such value-based changes to recover costs.

Key Takeaways

CMS is continuing to press its value-based strategy. When evaluating your approach to VBC, take a measured, gradual approach, and consider how external partners can support your internal resources.

The Growth of Medicare Advantage

The Medicare Advantage (MA) program has seen exceptional growth over the past few years, as roughly half of Medicare members are now enrolled in an MA plan. With these significant increases, there are several questions and implications, including those related to changing benchmarks and transitioning MA to an ACO-driven model.

MA and MSSP Alignment

There's an opportunity to align MA and MSSP and focus on parity. For example, the health equity index is designed to reward care for underserved populations enrolled in MA plans, similar to the health equity reward in MSSP. This, in turn, simplifies workflows and priorities for providers and globally drives VBC for both traditional Medicare and MA plans.

Value-Based Insurance Design

Value-based Insurance Design (VBID) targeting social determinants of health (SDOH) is another model the webcast discussed. This concept centers around clinical interventions and social support, where MA plans can address nutrition benefits, transportation, and other individualized needs.

Star Ratings

With respect to star ratings, the panelists mentioned a proposal to walk back a previous change that more heavily weighted patient experiences and complaints. They want to strike the right balance between patient experience and clinical outcomes.

MedPAC's Recommendations

With respect to MedPAC'a recommendations to change the MA benchmarking methodology, the presenters noted the predictability such adjustments would provide, but also pointed out the challenges to implementation and cautioned against moving too fast.

Responses to the agency's request for information from the public warned against moving too quickly. Panelists noted the need for ongoing engagement with plans, providers, patient groups, and manufacturers.

MedPAC's recommendations also included payment cuts by at least two percentage points, in order to achieve more balance, although the cuts could be more drastic.

There have been some specific cases where MA plans – which aren't all the same – have coded patient conditions and diagnoses more aggressively, due to incentives CMS didn't intend to create, producing a gap between FFS and Medicare Advantage.

The presenters expressed doubts the cuts would happen, noting the complexity of implementing benchmark changes.

Key Takeaways

The landscape surrounding Medicare Advantage is incredibly complex and politically heated. Most providers should prepare to move toward population health-based models for MA. Providers should also consider balancing the volume of these patients, and not focusing on Medicare Advantage despite the market growth. Many insurers might move toward profitable MA plans, but diversifying is likely to be wise for healthcare provider organizations.

Changes to Medicare Physician Fees

Many providers worry about shrinking fee structures and are watching for movement during Congress' lame duck session.

MedPAC representative, Michael Chernew, acknowledged that physician fees are under-pacing inflation and that MedPAC will be reporting in March 2024. In addition, while previous MedPAC meetings included discussions about recommendations around physician fees, he acknowledged the challenge in flat nominal physician fees and encouraged further stakeholder discussion on the issue.

Changes, described as "cuts," aren't necessarily a decrease because fees are merely returning to their pre-pandemic trajectories. Because the reimbursement for evaluation and management (E&M) codes increased, the so-called "cut" is designed to more broadly impose budget neutrality measures.

To offset the cost of paying more for E&M services, the conversion factor was reduced over multiple years, feeling like a "cut" to health care providers. However, whether considered a cut or not, this continues to be an area of great interest with an unclear future, though Mr. Chernew suspects there will be pressure on Congress to stall the payment changes. In addition, Mr. Chernew added physician payments will require attention beyond just these changes and will include telehealth.

In the meantime, MedPAC is paying close attention to providers that support the safety net – as well as how any potential payment policies affect sites of all sizes.

"Often, we have a small physician practice in mind," said Mr. Chernew. "There are a lot of small physician practices, but a growing number of physicians are now practicing [with] large organizations. When we talk about changes to physician payments, a lot of that money is going to the organizations those physicians work for. There's a lot of attention – historic MedPAC attention – on site-neutral payments."

Key Takeaways

With so much uncertainty over the direction of physician payments, providers should stay engaged on this topic. Strategic assessment of these changes and proposed changes can ensure alignment with operating goals.

Telehealth and Virtual Care

With the explosive growth of telemedicine, many providers wonder if policy corrections are an inevitability. Emphasizing that telehealth is very much on the MedPAC agenda, Mr. Chernew noted the need to balance the value of these tools with the understanding that blanket permissiveness carries with it some risks.

Remote Patient Monitoring

Remote monitoring has a lot of potential patient benefits, but at the same time, introduces regulatory compliance implications, payment complexities, and doesn't fit well within an FFS program. MedPAC plans to explore permanent solutions from a payment perspective.

Administrative Burdens

In addition, Mr. Chernew emphasized the potential administrative burdens of expanding the virtual care tools. For example, new technologies such as artificial intelligence (AI) interpretation often come with new billing codes. That raises questions about how to deal with the associated cost-sharing of those tools, for example, is a bill sent for each item or are services bundled?

These technologies make the case for broader payment models that don't require the administrative burden of delineating codes, according to Mr. Chernew. A patient who messages their providers raises the question of what constitutes care beyond the bounds of a visit?

As telehealth grows, MedPAC is watching these issues and will address them.

Key Takeaways

Health care providers should be aware of the many implications of a continuously digitized care continuum. Much of that includes the clinical impacts of remote monitoring, as well as the best way to approach technologies, such as AI-enabled clinical care.

Finally, providers should be cautious when billing telehealth services and engaging third-party telehealth vendors in light of warnings and fraud alerts from the Office of Inspector General (OIG), US Department of Health and Human Services, and others. Providers need to routinely assess and audit its processes and be aware of state and federal policies and licensing requirements, which can vary from state-to-state.

What Else We're Watching

Stakeholders should also pay attention to the following issues.

Traditional Medicare: Fee-for Service

Do not ignore traditional Medicare FFS regardless of the shift to Medicare-managed care. Over the next few years, providers can expect significant changes to traditional Medicare payment rates, refinements refocusing current reimbursement payments, and additional financial reporting requirements that could challenge hospitals to capture all available reimbursement.

Based on recent proposals, MedPAC recommendations, and the state of hospital financing, Medicare Disproportionate Share Hospitals (DSH) payments and wage index reporting may receive additional attention from policymakers.

Social Determinants of Health (SDOH)

The financial impact of SDOH measures is becoming more significant in Medicare FFS as well. For example, under the 2024 proposed IPPS rule, CMS is proposing to change the severity designation of ICD-10 diagnosis codes indicating a patient is homeless to *complication or comorbidity,* recognizing greater resource use for this population, and resulting in increased claims payment.

Further, health equity measures will be introduced into the VBC payment determinations. Gathering SDOH data is challenging, and hospitals should develop the supporting infrastructure to gather this data, as the number of metrics and financial impact are likely to increase in the coming years.

With the influx of these changes, providers should ensure there are sufficient staff to keep track of the many moving pieces and break through their departmental silos to collaborate across the organization.

Site Neutral Payments

While more care continues to shift from inpatient to outpatient settings and ambulatory facilities, Congress and CMS continue to review proposals that move toward site-neutrality payment methodologies for outpatient services.

The overall impact could mean significant reduction in hospital Medicare reimbursement. Hospitals should consider these potential changes in their long-term strategic planning.

Medicare Cost Reporting

More complexity has recently been introduced in Medicare cost reporting, a trend likely to continue as the focus remains on transparency. CMS released updates over the past months that greatly expand upon current reporting requirements and require immediate focus to ensure providers can report appropriately.

Acute care hospitals will face additional reporting require-

ments starting as early as next year that could impact reimbursement in a number of areas, including Medicare bad debts, Medicare DSH, Medicare DSH uncompensated care, and organ transplant reimbursement.

Medicaid Reimbursement

While CMS evaluates reimbursement for safety net hospitals and the care for underserved populations within the Medicare program, state Medicaid programs have also made these areas a priority.

Now more than ever, the potential for alignment between the two programs is expected. One potential change could involve Medicaid Disproportionate Share payments, which have been at risk since the passage of the Affordable Care Act. The deep cuts outlined in the legislation have been postponed, but not eliminated.

Current DSH hospitals should brace for reductions in or even elimination of these funds in the future, while also staying abreast of other hospital financing opportunities available for providers addressing underserved populations.

Medicaid Supplemental Payments

Other Medicaid supplemental payments are already addressing health equity issues in some states. Medicaid provider fee programs have introduced millions of dollars in additional reimbursement to supplement Medicaid payments.

Yet, in recent years, CMS has increased scrutiny of these programs, and the result has been uncertainty, reduced payments, and additional complexity. The underlying data used to determine payments in these programs has routinely been found incorrect or incomplete.

Providers need to understand what drives these payments, identify ability to obtain additional reimbursement dollars within these programs, and ensure the data being collected is complete.

Prepare for Changes from Commercial Payers

Implementation of the No Surprises Act and price transparency is driving significant change in the dynamic between payers and providers. Because payment rate information is now publicly available, payers can benchmark their current rates against the lowest rates for a given provider, with the potential to create a race to the bottom for providers.

Because the No Surprises Act protects patients when seeing out-of-network providers, payers are much more prepared to terminate contracts than they were previously, with network adequacy requirements one of the few sticks left to encourage payers to negotiate rates that allow providers to offset losses on providing care to uninsured, Medicaid, and Medicare patients.

Providers are approaching negotiations cautiously after enforcement actions from state attorneys general (AGs) and the Federal Trade Commission (FTC) as well as private lawsuits.

The landmark $575 million 2019 California AG settlement with Sutter Health put restrictions on their ability to negotiate with payers. More recently, four hospital mergers were blocked by the FTC because they could increase commercial reimbursement rates for those hospitals.

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Navigating the Uncertainty of State Abortion Laws: Suggestions for Hospitals Amid the Rise of Federal Investigations

Jessica M. Carroll

by Jessica M. Carroll

This article is brought to you by AHLA's Health Care Liability and Litigation Practice Group.

The uncertainty in state abortion laws has placed hospitals and physicians in an untenable position, one that could subject them to federal enforcement actions if, in compliance with state law banning or limiting abortions, they deny abortion services as emergency care treatment. In the wake of the U.S. Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*,[1] which overruled *Roe v. Wade*,[2] many states have responded by implementing restrictions on the administration of and access to reproductive care. This change is causing confusion for hospitals concerning compliance obligations under the Emergency Medical Treatment and Labor Act (EMTALA)[3] because the availability of abortion care in emergency situations is now limited.

The Patient Safety and Quality Improvement Act of 2005 (PSQIA)[4] establishes a medical error reporting system designed to assess and resolve issues related to patient safety and health care quality by identifying adverse events resulting from systemic failures.[5] The PSQIA and many parallel state statutes encourage medical professionals to engage in self-critical analysis and peer evaluation in a non-punitive, collegial setting to foster a culture intended to improve the processes rather than assigning blame. Its overarching goal is to promote patient safety. To prevent adverse events, particularly those resulting from inaction caused by uncertainty about the law, hospitals must stay abreast of federal law and understand how to navigate compliance if and when federal laws and state laws conflict.

To focus on the process, hospitals can prevent performance issues that negatively impact patient safety by utilizing a well-designed Ongoing Professional Practice Evaluation (OPPE) program. The Joint Commission launched the concept of the OPPE in 2007.[6] Intended for the purpose of improving performance and identifying trends and issues that could adversely affect patient outcomes, the OPPE process includes both qualitative and quantitative data to support re-privileging decisions. Qualitative data may include a description of procedures performed, types of patient complaints, code of conduct infractions, review of charting with consideration to quality and accuracy of documentation, relevance of tests ordered and procedures performed, and patient outcomes. Quantitative data reflects some type of unit of measure. Possible content within the quantitative category might include trends in length of stay, rates of post-procedure infection, frequency of missing information in charts, and noncompliance to rules, regulations, policies, or core measures.[7]

In situations where EMTALA creates a conflict between federal and state law, using an OPPE is an effective tool to preemptively avoid a violation. Said differently, providing medical staff with periodic education and review of federal standards in conjunction with state requirements would not only save the putative patient from an adverse event following a medical emergency, but it would simultaneously avoid a federal investigation into whether emergency care was denied inappropriately.

What Is EMTALA

EMTALA requires Medicare-participating hospitals with emergency departments to screen for and treat an emergency medical condition (EMC) in a non-discriminatory manner regardless of the patient's ability to pay.[8] An EMC includes medical conditions with acute symptoms of sufficient severity that could place the patient's health or bodily functions in serious jeopardy in the absence of immediate medical attention.[9] An EMC also exists when there is insufficient time to transfer the patient to another facility, or if the transfer might threaten the patient's safety.[10]

Under EMTALA, the examining physician(s) or other qualified medical personnel at the hospital have an obligation upon presentation to use clinical judgment to screen patients to determine whether an EMC exists.[11] In addition, EMTALA requires medical professionals to either provide necessary stabilizing care[12] or to facilitate an appropriate transfer if the hospital does not have the capacity to stabilize the EMC.[13]

Hospitals have a continuing professional and legal duty to provide all medically necessary stabilizing treatment. This means that hospitals and medical professionals must act before the patient's condition declines. This continuing obligation ends only when (1) the EMC no longer exists, (2) the patient is appropriately transferred to another facility, or (3) the patient is stabilized or admitted for further stabilizing treatment.14 The hospital's obligation to stabilize the patient means that it cannot deny emergency care for a patient with an EMC.

Concisely stated, hospitals and medical staff have three obligations: (1) to provide an appropriate medical screening examination to determine whether an EMC exists; (2) to provide available medical stabilizing treatment within the hospital's capacity if the clinical assessment determines an EMC exists; and (3) to transfer a patient to another hospital upon request, or if necessary, once the patient has been stabilized, when a physician certifies that the medical benefits of the transfer outweigh the risks.[15] Failure to comply with EMTALA has consequences for hospitals, as well as for physicians working in the emergency department or on call to the emergency department.

How EMTALA Applies to Reproductive Care

Being pregnant is not in and of itself an EMC – the trigger is the pregnant patient's need for medical evaluation or screening and stabilization in the presence of an EMC. For a pregnant patient, an EMC includes active labor, abdominal pain resulting from an ectopic pregnancy, complications of pregnancy loss, or emergent hypertensive disorders including preeclampsia. The clinical circumstances may require an abortion to terminate the pregnancy to stabilize and treat the presenting EMC.

On July 11, 2022, at the direction of the U.S. Department of Health and Human Services (HHS), the Centers for Medicare & Medicaid Services (CMS) issued a memorandum16 to State Survey Agency Directors and a letter[17] from Secretary Xavier Becerra reaffirming the EMTALA requirements for health care providers and reminding them of their professional and legal duties to provide stabilizing care to patients presenting with an EMC. CMS made clear that EMTALA preempts any state law or mandate that is directly in conflict with it–meaning that there is a federal obligation to offer stabilizing care to pregnant women even when it requires performing an abortion to medically stabilize the patient in a state where abortion is banned. Emergency care cannot be denied.

This means that if a pregnant woman presents to an emergency room, and the examining provider's clinical judgment is that an EMC exists, EMTALA allows the hospital to perform an abortion if it is within the hospital's capabilities, even if state law prohibits such services. Performing an abortion must be an appropriate stabilizing treatment that is medically necessary to reasonably assure that there will be no material deterioration of the EMC or of the patient.

On May 1, 2023, the CMS announced two federal investigations into hospitals that denied necessary stabilizing care to a pregnant patient experiencing an EMC. The investigations related to a patient who initially went to a hospital in Missouri and then to a hospital in Kansas. At nearly 18 weeks pregnant, the woman presented with a preterm premature rupture of membranes. Medical providers at both hospitals told her that hospital policies prevented them from providing her with medical stabilizing care because it would terminate a pregnancy where the fetal heartbeat was still detectable and, therefore, could be considered an abortion under their state laws.[18]

CMS identified these two responses as a violation of EMTALA. Despite recognizing that her condition could rapidly deteriorate and that her pregnancy was not viable, she was denied medical stabilizing care that would prevent infection, hemorrhage, or potentially death, because of the conflict between state and federal law. As a result of these investigations, Secretary Becerra sent a letter to all hospital and provider associations emphasizing their ongoing obligations under EMTALA to provide stabilizing treatment, including abortion care or an appropriate transfer, to Medicare-participating hospitals despite this conflict.[19]

This example illustrates how inaction or deterrence on behalf of a hospital and medical staff can lead to a federal investigation. Although the patient survived, this incident highlights the uncertainty regarding the interplay between hospital procedures, state law, and federal law in a way that can jeopardize patient safety and quality of care.[20] Such uncertainty and misunderstanding may ultimately undermine the hospital's interest in promoting the best quality of care. Essentially, confusion surrounding compliance and a risk-adverse culture has effectively created deterrence, a refusal to treat, and denial of emergency care.

How an OPPE Can Avoid Federal Investigations and Adverse Outcomes

Hospital administration, along with the attending medical staff, department heads, and persons involved in quality and risk management, are responsible for monitoring compliance with EMTALA. Ensuring that treatments, or failures to treat, do not adversely affect a patient's health is instrumental to preventing summary suspensions and a federal investigation related to EMTALA. This requires hospitals and members of the medical staff to understand their professional and legal du-

ties under EMTALA. To accomplish this, establishing policies incorporating the hospital's requirements and finding an effective way of disseminating such information is critical when the stakes can be high.

Failure to comply with EMTALA may result in civil monetary penalties by the Office of Inspector General, exclusion from Medicare and state health care programs, or termination of the hospital's provider agreement by CMS.[21] Additionally, failure to comply can result in civil suits filed by private citizens who are harmed by the hospital or health care provider's failure to perform medically necessary stabilizing treatment to prevent the patient's deterioration in emergency situations.[22]

When faced with a complex regulatory system such as EMTALA, continuous monitoring of the medical staff is a form of preemptive and preventative action. Hospitals could use an OPPE to self-monitor, protect patient safety, promote the best quality of care, and ultimately ensure compliance with EMTALA. An OPPE is a peer review function and part of the collegial intervention process to promote collaboration in furtherance of patient safety. Collegial intervention efforts often involve reviewing competency issues or the conduct of physicians on a hospital's medical staff. It may also include educating medical staff members regarding applicable policies or changes in the law, proctoring for newly admitted medical staff members, or sharing comparative information from various clinical practices to promote conformity across the hospital network.

Educating the medical staff on the requirements for appropriate screening, stabilization, and transfer of patients presenting with an EMC to hospitals' emergency departments will inevitably lead to better quality of care.

However, presenting this information in conjunction with the applicable hospital policies by highlighting situations that present possible conflict between federal and state laws simultaneously identifies systemic failures that could prevent avoidable occurrences and potentially result in an adverse outcome. Disseminating the information in a non-punitive, collegial setting through peer review and self-critical analysis will prevent inaction and deterrence by focusing on improving the processes rather than assigning blame. In the end, it will achieve the hospital's overall objective to promote quality of care and ensure patient safety.

About the Author

Ms. Carroll is with Greenbaum Rowe Smith & Davis LLP , and concentrates her practice in litigation, with an emphasis on representing hospitals in medical staffing and peer review disciplinary matters arising out of issues related to quality care and patient safety that sound in breach of contract, violations of due process and fundamental fairness, defamation and trade libel claims, as well as matters related to professional licensure and credentialing. Her work also includes handling anti-competitive claims alleging violations of New Jersey's Anti-Trust Act, the Sherman Anti-Trust Act, and the Lanham Act, in addition to employment claims, including violations of the New Jersey Law Against Discrimination (NJLAD) and the Conscientious Employee Protection Act (CEPA), in state court, federal court, and in arbitrations. She can be contacted via e-mail at jcarroll@greenbaumlaw.com.

Footnotes

[1] *Dobbs v. Jackson Women's Health Organization*, 597 U.S.__ (2022).

[2] *Roe v. Wade*, 410 U.S. 113 (1973).

[3] EMTALA is codified in Sections 1866 and 1867 of the Social Security Act (42 U.S.C. §1395dd), and in the regulations and interpretive guidelines adopted by the Centers for Medicare and Medicaid Services (CMS).

[4] 42 U.S.C. §§ 299b-21 – 299b-26.

[5] 42 U.S.C.A. § 11101 et seq.

[6] Skip Freedman, MD, *Peer Review: How 2007 Joint Commission Standards Expand Hospital Peer Review – Patient Safety & Quality Healthcare* (Sept./Oct. 2007), https://www.psqh.com/analysis/peer-review-how-2007-joint-commission-standards-expand-hospital-peer-review/.

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[9] Dep't of Health and Human Servs. (HHS), Press Release, *Statement by HHS Secretary Xavier Becerra On House Republicans Introducing Legislation to Rip Away Women's Access to Contraception and Abortion Medication* (Sept. 14, 2022),

https://www.hhs.gov/about/news/2022/09/14/statement-by-hhs-secretary-xavier-becerra-house-republicans-introducing-legislation-to-rip-away-womens-access-contraception-abortion-medication.html.

[10] *Id.*

[11] 42 C.F.R. § 489.24(a)(1)(i).

[12] 42 C.F.R. § 489.24(a)(1)(ii) and (d).

[13] 42 C.F.R. § 489.24(a)(1)(i), (d), and (e).

[14] HHS, Press Release, *Statement by HHS Secretary Xavier Becerra On House Republicans Introducing Legislation to Rip Away Women's Access to Contraception and Abortion Medication* (Sept. 14, 2022), https://www.hhs.gov/about/news/2022/09/14/

statement-by-hhs-secretary-xavier-becerra-house-republicans-introducing-legislation-to-rip-away-womens-access-contraception-abortion-medication.html.

[15]42 C.F.R. § 489.24(a)(1)(i); 42 C.F.R. § 489.24(a)(1)(ii) and (d); 42 C.F.R. § 489.24(a)(1)(i), (d), and (e).

[16]HHS, QSO-22-22-Hospitals, *Reinforcement of EMTALA Obligations Specific to Patients Who Are Pregnant or Are Experiencing Pregnancy Loss* (last rev. Aug. 25, 2022), https://www.cms.gov/files/document/qso-22-22-hospitals.pdf.

[17]Letter from Xavier Becerra, Secretary, HHS, and Chiquita Brooks-LaSure, Administrator, Ctrs. for Medicare & Medicaid Servs., to Health Care Providers (July 11, 2022), https://www.hhs.gov/sites/default/files/hhs-letter-to-governors-reproductive-health-care.pdf.

[18]Amy J. Dilcher and Arushi Pandya, *EMTALA and Pregnancy Care Remains a Federal Enforcement Priority*, NAT'L L. REV., May 17, 2023, https://www.natlawreview.com/article/emtala-and-pregnancy-care-remains-federal-enforcement-priority.

[19]HHS, Press Release, *HHS Secretary Xavier Becerra Statement on EMTALA Enforcement*, (May 1, 2023),

https://www.hhs.gov/about/news/2023/05/01/hhs-secretary-xavier-becerra-statement-on-emtala-enforcement.html#ftnref1.

[20]Katherine Dillinger and Nadia Kounang, *Two hospitals under federal investigation over care of pregnant woman who was refused abortion*, CNN, May 1, 2023, https://www.cnn.com/2023/05/01/health/emtala-hospital-investigation/index.html.

[21]HHS, QSO-22-22-Hospitals, *Reinforcement of EMTALA Obligations Specific to Patients Who Are Pregnant or Are Experiencing Pregnancy Loss* (last rev. Aug. 25, 2022), https://www.cms.gov/files/document/qso-22-22-hospitals.pdf.

[22]*Id.*

•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	via Teams
Co-Chair: Tara Bogart – tara.bgart@pmmconlne.com	(704) 618-1531	9:00 AM	
Board Liaison: Kim Keenoy – kim.keenoy@bofa.com	(732) 321-5935	Access Code: 89425417190	
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		

How to Expedite Payment for Your VA Claims

Jason Smartt

by Jason Smartt, Esq.

Operating a hospital or health system means layers upon layers of challenges, from managing staff to developing the right clinical programs and improving patient experiences. Among those challenges, navigating complex Veterans Administration (VA) claims stands out as a particularly intricate task. For healthcare providers managing their claims in-house, it's crucial to understand the complexities inherent in working with the VA and how to effectively address the pain points associated with these claims.

The Complexity of VA Claims: A Multifaceted Challenge

If the VA does not have room to treat a veteran or if there is not a facility within a veteran's community, eligible veterans can seek care at "community providers" – hospitals that sign up and meet minimum requirements to serve veterans.

There are often obstacles to receiving the necessary treatment. Providing care to veterans can present challenges for community providers seeking reimbursement and payment. Unlike private insurers, the VA operates within a web of regulations, policies, and guidelines that can be daunting to navigate. Pain points associated with VA claims often include:

- **Denied claims and appeals:** The rate of claim denials from the VA can be higher than that of private insurers, and the appeals process is particularly difficult.
- **Regulatory changes:** The VA is subject to constant regulatory changes and policy updates. Staying compliant requires dedicated effort and resources.
- **Coding and billing challenges:** VA claims have unique coding requirements that differ from those of other payers. Incorrect coding can lead to denials, delayed or incorrect reimbursement. Proper coding, particularly for service-connected conditions, requires expert knowledge and attention to detail.
- **Inconsistent payment rates:** Reimbursement rates from the VA differ from those paid by Medicare, Medicaid, and private insurers.
- **Limited network agreements:** For cases where VA facilities lack the necessary resources or capacity, veterans may seek treatment from community providers. This brings its own set of challenges, including authorizations, documentation and reimbursement.

If the VA does not have room to treat a veteran or if there is not a facility within a veteran's community, eligible veterans can seek care at "community providers" – hospitals that sign up and meet minimum requirements to serve veterans.

As a government agency, the VA is in a constant state of expansion, modification of procedures, and ever-changing regulations and policies. Many revenue cycle teams don't have the bandwidth or expertise to keep up with changing regulations or chase after denied claims or underpayments. The last thing a hospital or health system wants is for a patient's claim to be denied, forcing them to pursue payment from the patient or send the claim to charity care – especially when that patient is an active-duty or retired service member relying on them for care.

That's why a partner that specializes in complex claims is invaluable. Handing VA claims to a trusted partner that specializes in complex claims means your revenue cycle team can re-allocate staff to focus on other, more important tasks.

About the author

Jason Smartt, Esq., is Vice President, Policy and Complex Claims, with EnableComp. He can be reached at jsmartt@enablecomp.com.

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Creating Work-Life Balance & Finding Purpose in What You Do

Lisa Hammett

by Lisa Hammett

Finding purpose in life is a deeply personal and introspective process. When you're living into your purpose, your life has meaning. You feel fulfilled and are passionate about what you're doing. Your life is in alignment and has balance. You have strong mental clarity, including a sense of direction. You are happy, peaceful, and feel empowered. You look at challenges as learning opportunities.

Finding purpose is a journey, not a destination. It's a fluid process that involves exploring different paths and adjusting goals as needed. Here are 7 key elements for creating a purpose driven life.

Element One
Create a Laser-Focused Vision

A Laser-Focused Vision incorporates your core values, passions, and strengths.

Step 1 – Identify Limiting Beliefs

Identify limiting beliefs that you're not good enough or deserving enough to have what you desire.

Find someone you trust and are comfortable talking to. This could be a coach, pastor, counselor, or mentor. This person must be objective. You may feel comfortable talking to a close friend or family member, but they are not always objective. A coach or counselor can be particularly helpful in asking the right questions that identify potential roadblocks. Through purposeful reflection, awareness of negative beliefs will materialize and can be released.

Step 2 – Believe that Your Vision is Possible

Create the belief that positive change is possible. Mental fitness is an effective tool for shifting mindset from the negative to the positive. This is done through a series of micro-meditations, called PQ reps, which engage the senses.

One PQ rep may involve intently focusing on something you can see, by noticing tiny details, such as colors, shapes, textures, or a reflection in the surface.

Another PQ rep could involve something you can hear, by focusing on the most distant sound you can hear, then transferring your focus to the sound of your breathing.

A third PQ rep could involve your sense of touch. This may involve rubbing two finger tips together and noticing the fingertip ridges, the temperature of the fingertips, and the texture.

Are they dry or are they smooth?

PQ reps take the focus off the negative emotion, putting the mind in a neutral state. Once the negative emotion is quieted, it's possible to shift to a positive mindset, and the belief that positive change is possible.

Step 3 – Allow Yourself to Dream

Reflect on your core values, passions, and strengths. What is most important to you in life?

Why is it important?

Envision a life that is aligned with your core values, passions, and strengths. What are you doing? Who are you with?

Attach emotions to your vision. How will you feel when you are living into your purpose? This will bring life to your vision.

Element Two
Set SMARTER Goals

S – Specific
M – Measurable
A – Active
R – Relevant
T – Time Bound
E – Energizing
R - Realistic

When setting SMARTER Goals, consider the impact you want to make on the world and who you want to surround yourself with. How do you want to contribute to society, your community, and your field of interest?

Incorporate learning opportunities into your SMARTER Goals. Continuous growth and development can provide a sense of purpose as you work towards becoming the best version of yourself.

Consider how you'll help others. Acts of kindness and service can give a profound sense of purpose. SMARTER Goals may incorporate volunteering, mentoring, or spending time with friends and family.

Review SMARTER Goals monthly and make adjustments as needed.

Element Three
Create Weekly Action Items

Action items are those daily steps (habits) that help you reach your SMARTER Goals.

For example, if one of your goals is to lose weight, action items may include: meal prepping, tracking food, being active, and getting good sleep.

Element Four
Practice Daily Gratitude

Taking time to appreciate what you have and acknowledging the positive aspects of your life can help you find meaning in everyday experiences.

Practicing gratitude may involve thinking of three things you're grateful for each day or journaling what you're thankful for.

Element Five
Recite Daily Positive Affirmations

Positive Affirmations are a statement of fact that is attached to a SMARTER Goal and is stated in such a way that the goal has already been achieved.

Ex: I choose to be happy and healthy

Element Six
Set Healthy Boundaries

Setting healthy boundaries involves the following:
Protect Your Energy
Say NO
Manage Your Time

Protecting energy involves limiting exposure to negative influencers, such as: news sources, social media, toxic people, toxic environments.

Learning to say no can be challenging but becomes easier the more you do it. This involves saying no to tasks or social outings that cause stress and prevent you from practicing self-care.

A simple "no thank you" or "I'm unable to attend" will suffice. Do not provide a dissertation and by all means, do not apologize for saying no. You should never apologize for prioritizing your self-care.

Saying no in the workplace can be scary. We do not want to appear unhelpful and not a team player. If by saying yes you are creating unnecessary stress and compromising productivity, it is essential to say no.

If you are unable to take on a particular task, concisely state that you are concerned about doing the job well, and provide a solution.

When managing time, time block self-care, family time, lunches, and breaks. If you are answering work emails or texts late in the evening and after hours, you are inadvertently telling your employer that you have no work boundaries.

Element Seven
Find an Accountability Partner

An Accountability Partner is supportive and encouraging and holds you accountable when challenges arise. It's important to find someone who is objective. Clearly communicate to your Accountability Partner the type of support you need.

When creating your purpose driven life, it's important to remain flexible. What gives you purpose today might be different from what gives you purpose in the future. Be open to reevaluating and adjusting your goals and needs.

Lastly, surround yourself with like-minded individuals wo share similar values and interests. This can be very motivating and help reinforce your sense of purpose.

About the author

Lisa Hammett is the author of the book, From Burnout to Best Life, How to Take Charge of Your Health & Happiness, and an accomplished motivational and TEDx speaker, an international best-selling author, a Certified Positive Intelligence PQ Coach, and a wellness expert, helping stressed and burned out Executives and Leaders in Healthcare and HR develop mental fitness to manage stress, improve productivity and communication, and regain their health and wellbeing. She reached burnout, after 26 years in the corporate retail sector. After a transformative health and wellness journey, where she lost 65 pounds, Lisa decided to dedicate her life to helping others achieve their health and wellness objectives. She has empowered thousands of individuals to make sustainable, healthy lifestyle changes.

Lisa can be reached at info@lisahammett.com.

hfma

new jersey chapter

Dear Fellow HFMA Members:

I am pleased to invite members, member's spouses, or member's dependents to apply for this year's 2024 HFMA Scholarship. The New Jersey Chapter of HFMA will be offering at least one scholarship at a minimum of one thousand dollars. You, your spouse or dependent may be eligible for the scholarship if you meet the following criteria:

- Member, in good standing, of the New Jersey Chapter for the last two years.
- Spouse or dependent of a member, in good standing, of the New Jersey Chapter, for the last two years.
- Enrolled in an accredited college, university, nursing school or other allied health professional school.

Preference will be given to applicants pursuing degrees in finance, accounting, healthcare administration or a healthcare related field of study. Tuition not paid by an employer or other scholarship will qualify for the HFMA scholarship.

We make our selection based on merit, academic achievement, civic and professional activities, course of study and content of your application and essay. We do not use income in our selection process. To apply, please submit a completed Scholarship Application no later than March 15, 2024. Members of the Chapter's Board of Directors, Officers and Advisory Council and their spouses or dependents are not eligible for scholarships. Prior awardees are not eligible for a subsequent scholarship, although other dependents in the member's family are still eligible.

We will announce the recipient(s) of the 2024 NJ HFMA Scholarship at our annual golf outing on May 9, 2024. If you have any questions or wish to receive additional applications, please contact Laura Hess at njhfma@aol.com.

We look forward to receiving your application and wish you success in your academic endeavors.

Respectfully submitted,

Brian Herdman

Brian Herdman
Chair, 2024 Scholarship Committee

NEW JERSEY HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION MEMBER'S ANNUAL SCHOLARSHIP APPLICATION

MEMBER INFORMATION

Member Name _____
Member Address _____
_____
Membership # _____

Years in HFMA _____ # Years in NJ Chapter_____

Member Employer _____

APPLICANT INFORMATION
PART 1 - PERSONAL DATA

Applicant Name _____
Address _____
_____
Relationship to Member_____ _____
College _____
_____
Course (s) to be taken _____
_____

Matriculated Student YES _____ NO _____
Degree/Program Pursued _____
Anticipated Graduation Date _____
Major _____Annual Tuition _____
Amount of Employer Support _____
Amount of Other Scholarships Awarded _____

(Documentation must be provided supporting tuition and/or books, employer's reimbursement policy and enrollment in school.)
(Please label as Attachment D.)

PART 2 – EDUCATION BACKGROUND

Highest Level of Education Attained _____
School _____
_____
GPA _____ Degree_____ Major _____

(Documentation must be provided documenting Grade Point Average)

PART 3 – PROFESSIONAL CAREER

Employment History (**List employment history as Attachment A**.)

PART 4 – COMMUNITY AND PROFESSIONAL ACTIVITIES

Please describe your civic and professional activities and contributions to your community, profession, HFMA or other organizations. (**Please label as Attachment B.**)

PART 5 - ESSAY

Please submit an essay describing your educational and professional goals and how this scholarship will assist you in achieving such goals. (**Please label as Attachment C**.)

PART 6 - REFERENCES

Please furnish three formal reference letters

SIGNATURE _____ DATE _____

Please return completed package no later than March 15, 2024 to:

Brian Herdman at NJHFMA@aol.com or mail to:
Chair Scholarship Committee, NJHFMA
Healthcare Financial Mgmt. Assoc. - NJ Chapter
PO Box 6422
Bridgewater, NJ 08807

WANTED

NJ HFMA Associate Board Member

Are you driven, innovative, and committed to promoting the healthcare financial management field? Are you a healthcare leader who can nudge an up-and-coming Star to take a step in their career and obtain visibility?

The NJ Chapter of HFMA is currently seeking individuals that are interested in becoming an Associate Member of the Board of Directors. This is a unique opportunity to work with healthcare leaders in New Jersey in defining and promoting our education and networking mission.

The requirements for application include:

- ✓ Current membership in HFMA
- ✓ The New Jersey Chapter of HFMA selected as your primary chapter
- ✓ Membership in HFMA 5 years or less
- ✓ A referral from a senior administrator in your organization
- ✓ A letter stating why you would like to be an Associate Board Member of the Board of Directors
- ✓ Copy of your resume
- ✓ Willingness/ability to attend the majority of the monthly board meetings on the second Tuesday of the month from 7:30am - 9:00am.
- ✓ Willingness to participate in a New Jersey Chapter Committee

The Associate Board Member position is a two-year appointment. There is one Associate Board Member position available for the 2023-2024 Chapter year (with a start date of June 1, 2024). The Associate Board Member position is a non-voting position.

If interested, please forward the above requested requirements to Laura Hess at njhfma@aol.com

The deadline for your submission is January 27, 2024

•Focus on Finance•

Cyber Attacks on the Rise: The Growing Threat to Healthcare

Jason Spezzano

By Jason Spezzano

The number of cyber incidents within the healthcare industry has continued to increase, ranging from isolated incidents to targeted attacks that have grown in their material impacts. Hospitals and medical practices that fall victim to cyber-attacks can be left figuring out how to operate without their daily information systems. This has led to patients receiving incorrect medicine dosages, delayed operations, and diverted healthcare, such as ambulances being rerouted to other facilities, threatening patient lives. Patient data being exposed has also led to class action lawsuits, causing reputational impacts and significant losses in revenue. This year, the first healthcare organization stated that it was going out of business due to a ransomware attack.

Q. What industry is most at risk for cybersecurity threats?

A. In 2022, U.S. healthcare organizations were the most compromised of any industry for the third straight year.[1] HHS OCR reporting of breaches in 2023 reflects approximately 440 breaches impacting 76.5 million individuals compared to 37.5 million affected in all of 2022. That represents a 100% increase in impacted individuals in only 8 months in 2023.[2]

- In July of this year, 2023, Hospital Corporation of America (HCA) suffered a healthcare record-breaking breach impacting 11 million records. HCA Healthcare now faces four class-action lawsuits.
- Another example is Prospect Medical Holdings – a Los Angeles-based company that operates 16 hospitals and 165 outpatient facilities across California, Texas, Pennsylvania, Connecticut and Rhode Island. This year, it took its main computer network offline due to a ransomware attack that was claimed by a ransomware group called Rhysida.[3] Outpatient facilities closed, in some cases, prospect-owned emergency rooms had to close, and ambulances had to be diverted. Law firms are collecting names of impacted individuals for potential class action.
- In September of this year, Nuance Communications announced a data breach that occurred in May due to a cyber-attack from a ransomware gang known as CL0P impacting approximately 1.2 million users at 13 hospitals and medical companies in North Carolina, Pennsylvania and West Virginia. Law firms are currently collecting names of impacted individuals for potential class action.

Q. How can I protect my organization?

A. Current cyber trends reflect a continued and growing challenge to mitigate operational impacts and protect patient data within healthcare organizations. Healthcare organizations and their staff must be prepared for a cyber-attack in order to continue operations during a cyber event. This starts by implementing the required administrative, physical and technical safeguards. It is up to covered entities to look at their daily operations and determine the best options, as cybersecurity is not a one-size-fits-all approach, although many practices are the same across healthcare firms. Incident response planning, continuity of operations plans and disaster recovery plans are critical to avoid material and long-lasting impacts. Organizations should have their cybersecurity program and controls independently reviewed to clearly understand the programs' maturity and identify any recommended enhancement.

About the author

Jason Spezzano, is Executive Cybersecurity Advisor, at Withum. He can be reached at spezzano@withum.com.

Footnotes

[1]"Identity Theft's Resource Center's 2022 Annual Data Breach Report Reveals Near-Record Number of Compromises," Identity Theft Resource Center

[2]U.S. Department of Health and Human Services Office for Civil Rights (HHS OCR) Breach Portal: U.S. Department of Health & Human Services - Office for Civil Rights (hhs.gov)

[3]Withum - Cyberthreat Analysis Report - Healthcare 2023

NJ HFMA: Who We Are

On a recent call of the Communication Committee a participant asked the question "Who are our members?" Years ago the Association used to make available to the Chapters a composite of their membership, showing affiliation, title, job function, average age, etc. I reached out recently to the Association to see if this infromation was currently available, but unfortunately they no longer maintain that report. But the Chapter Roster does contain much of the information, so with the help of Microsoft Excel I was able to create the following pictures of the NJ HFMA memnership.

Organiztion Type:		
Hospital or Medical Center	501	48.9%
Health System Corporate Offices	129	12.6%
Consulting Firm	68	6.6%
Accounting Firm	35	3.4%
Educational Institution	37	3.6%
All Others	254	24.8%
Total Membership @9/2/2023	1024	100.0%

Job Level:		
CFO	47	4.6%
President/CEO	34	3.3%
Vice President	99	9.7%
Director	202	19.7%
Manager/Supervisor	174	17.0%
Staff Specialist/Analyst/Accountant	239	23.3%
All Others	229	22.4%
Total Membership @9/2/2023	1024	100.0%

Membership Category:		
Professional All Access	276	27.0%
Busness Partner All Access	135	13.2%
Enterprise Professional All Access	415	40.5%
Enterprise Business Partner All Access	109	10.6%
Student All Access	63	6.2%
All Others	26	2.5%
Total Membership @9/2/2023	1024	100.0%

A quick explanation may be necessary regarding the last table. The Association initiated the Enterprise Member Program a few years back to allow entities to join HFMA as a group, often leading to savings over individual memberships. If you are interested in learning more about this program please contact any of the Chapter's Officers or Board Members.

Source: NJ Chapter Roster 11/1/2023

• Committee Corner •
Spotlight on the Communications Committee

One way the New Jersey HFMA Chapter keeps members apprised of important issues affecting the delivery of healthcare as well as highlighting activities from around the Chapter is through the quarterly publication of the Garden State *FOCUS*, produced by the Communications Committee. At one time the *FOCUS* was exclusively mailed to our members, but due to many readers working remotely as well as the ongoing changes in the delivery of content, it is now mostly digital, with a single printed edition distributed at the Annual Institute. Many professional journals are making the switch to digital only publishing if they haven't already. Through the Chapter's website you can access the current edition as well as prior issues.

A great deal of effort and coordination is necessary to produce the Garden State *FOCUS*. Leading these efforts is Jim Robertson, our Editor. Each edition includes the column "From the Editor…", in which Jim provides a synopsis of the articles contained therein. It's also not unusual to see articles authored or co-authored by Jim, as he has been a consistent contributor to the *FOCUS* throughout the years. Assisting Jim and fulfilling the coordination role is Chapter Administrator Laura Hess. She's the person who works behind the scenes to keep the Communication Committee on track by managing the flow of articles, coordinating meetings of the committee and acting as liaison with the printer. Needless to say, without Laura none of this would be possible. Assisting Jim and Laura is Brian Herdman, the current Board Liaison to the Communications Committee and prior Co-Editor of the *FOCUS*.

What attracted you to the Chapter's Communications Committee and when did you first become involved?

Jim: I first became involved with the Communications Committee in 2004 after the publication of my first article in Garden State *FOCUS* on Bioterrorism Preparedness in New Jersey. Bioterrorism preparedness was top of mind following the 9/11 attacks and federal and state governments were focusing their efforts almost exclusively on being prepared for the next terrorism attack. I remember wondering at the time whether the NJ HFMA membership would appreciate and find value in an article that was slightly outside the norm for the type of articles I had historically seen published in the magazine. My questions were quickly answered with an overwhelmingly positive response to the article from the membership. As a result, I began to regularly submit articles for publication that I thought would be of interest to the NJ HFMA membership on a variety of legal topics that I was either encountering in my private legal practice, or that were interesting developments in the healthcare legal landscape. Through this experience, I learned that I indeed had something valuable to contribute to the NJ HFMA ecosystem.

Laura: I think I first got involved with the committee in 2001. I was recruited to help with all the administrative tasks involved with pulling together the issues. Coordinating all of this was a heavy load for the editor, as volunteers had less hours to give. I ensure the articles received contain the needed components, coordinate and gather all the edits on each issue, handle the advertising and act as the liaison with the printer. For me this was perfect as advertising/design was my minor in college – right up my alley!

Are there special talents that you have that you feel make this a good fit for both you and the committee?

Jim: As an attorney, I write a lot! As the chair of my law firm's healthcare practice, I manage people, cases and projects. And, as a practicing hospital reimbursement attorney, I regularly handle Medicare/Medicaid cost report appeals before the federal Provider Reimbursement Review Board (PRRB) and state Office of Administrative Law (OAL), annual charity care, Graduate Medical Education (GME), and mental health subsidy appeals, Medicare Disproportionate Share Hospital (DSH) appeals and Medicare Advantage/Medicaid managed care payer audits and claims denial appeals. By volunteering on the Communication Committee I have been able to leverage my skills and expertise to contribute valuable perspectives on real-time hospital reimbursement issues and be part of a team that presents those perspectives to the broader NJ HFMA membership through the Garden State *FOCUS*.

Laura: Wow, Jim, how did you let me talk you into this??? Ha ha!

As I mentioned, advertising and design have always been interests of mine, so when I was asked to participate in putting this award-winning magazine together, I was thrilled!

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

Jim: I am a partner in the 100-attorney New Jersey law firm of Greenbaum, Rowe, Smith & Davis LLP and the Chair of our firm's Healthcare Department. While I focus a large portion of my own client work on hospital reimbursement matters, I manage a comprehensive healthcare practice which consists of 17 attorneys who provide the full range of legal services to our healthcare clients. On the personal side of things, my wife Patricia and I will be married for 30 years next year and, because we are both attorneys, often have spirited debates about the issues of the day, most of which, I will freely admit, she usually wins. I am an avid Chelsea fan, much to the chagrin of my two sons, James (who is a Liverpool fan) and John (who is a Manchester United fan). Fun fact: At age 11, I was the first player to score a goal in an official soccer game in the original Giant Stadium where my travel soccer team from Bergenfield, New Jersey played a soccer game before the Cosmos' home-opener game.

Laura: I am a little nuts. I like to be busy and I have three jobs…. yep three. I have been the billing manager with Atlanticare for a year and a half now, I have served in my role as Chapter Administrator for our NJ HFMA Chapter for 23 years, and I have also been a recruiter for 9 years.

In my free time I love to travel, enjoy the beach, cook, and spend time with my family, who luckily also enjoy the same things. I have been married to my husband Jim for 31 years, and we have two kids – Luke, 24, also in healthcare, and Julia, 21, who is a senior at Seton Hall. We also have 2 cats, Snoop and Martha who are great entertainment.

What do you see as some of the challenges in producing a publication like the Garden State FOCUS, with its long history of keeping our members informed of what's happening in the Healthcare arena both locally and nationally?

Jim: With the advent of readily available "real time" news from online (digital) media and via social media, it is now harder than ever for traditional publications, like Garden State *FOCUS*, to deliver timely and fresh perspectives on the pressing local and national issues facing the healthcare industry. I am proud to say that we have succeeded in covering the most current and relevant topics in each issue of Garden State *FOCUS*. This is no small task, and our success can be attributed directly to the unwavering commitment of the dedicated members of the Communications Committee. The Communications Committee prides itself on having a strong camaraderie among its members who, with each successful Garden State *FOCUS* issue, demonstrate a respect and devotion to the task of producing the finest publication HFMA has nationally. However, the future of the Garden State *FOCUS* rests directly in the hands of the next generation membership of NJ HFMA. To continue being a valuable resource, the Communications Committee needs to tap into the new and fresh perspectives of our younger members. Adding the perspective that only younger professionals can bring to the table will ensure the Garden State *FOCUS*' future success. We, the Communications Committee, welcome anyone who would like to share their time and talent and help us continue publishing this high-quality magazine for our membership.

Laura: I think the biggest problem for any publication these days is to stay relevant and top of mind for members. With everything being electronic and news being "real time", that has become increasingly more difficult.

And as Jim mentioned above, we are lucky as we do have a great group of people on the committee who have become friends and who work together so well. We would love to have some new members with new ideas join us and help us to continue to be a valuable resource.

Can you describe the process from initial discussion to final publication of the Garden State FOCUS?

Jim: The time period from initial discussion to final publication of an issue of Garden State *FOCUS* is approximately 8-10 weeks. The Communications Committee meets on the first Thursday of every month. At that meeting, the Committee identifies a theme for the upcoming *FOCUS* issue, potential topics and authors for articles, as well as special feature articles. Once the plan is set, members of the Committee reach out to authors for articles. A deadline is set – usually 5 weeks before the issue goes to production – to receive draft articles. The articles received are uploaded on Google Docs and Committee members are assigned specific articles to edit. We usually have 4-5 Committee members who will edit articles. While the articles are being edited, other Committee members finalize the layout of advertisements, pictures and recurring NJ HFMA Chapter announcements and upcoming events. After all articles are edited, the content is delivered to our publisher for final layout. Approximately one week before publication, the layout proof is created, and each Committee member is assigned specific page numbers to proofread and finalize. Once all final edits are received, a cover is chosen – usually corresponding to the season of the year in which the issue is being published – Spring, Summer, Fall, or Winter – and the final publication is uploaded onto NJ HFMA's website. The only Garden State *FOCUS* issue that is actually printed is the Annual Institute edition which is distributed to Annual Institute attendees at the event.

Laura: What he said.

What changes do you foresee in the near term and further out in how we address the needs of our members to keep them informed to better perform their job duties? Is there anything new we can be anticipating?

Jim: The mode of communications that is used to distribute information to members has and will, in the short run, continue to evolve toward digital platforms, including social media platforms such as LinkedIn, Instagram, Facebook, Twitter, and Tik Tok. Today, most of the magazine's content is posted on the NJ HFMA website in static form. In the not-too-distant future, this content will need to be delivered in a more interactive manner, to be consumed in real-time, requiring the Garden State *FOCUS* to adapt to becoming interactive as well. Add Artificial Intelligence (AI) to this real-time, interactive content consumption dynamic and we will see content being created before our readership even identifies the need for information, and in a fashion that can anticipate an individual member's needs and address them before those needs come into organizational consciousness. For NJ HFMA and the Garden State *FOCUS* to continue to bring value to its membership, we will need to leverage the power of AI to not only address, but to answer questions and issues our members are faced with in their work lives. If AI can be leveraged in this way, NJ HFMA's value proposition becomes exponential.

Laura: I agree that we do need to look at some new digital formats that might be more interactive and easier to navigate. That will be key in helping us to remain a relevant and valued publication.

Annual Holiday Social 2023


WARNING
"WELL DONE"


EXIT
ANTHONY'S
COAL FIRED PIZZA
TAKE OUT


NEW, UNWRAPPED TOYS ONLY
CAMPAIGN RUNS 1 OCTOBER
THROUGH DECEMBER
MARINE CORPS RESERVE
TOYS FOR TOTS
Welch Packaging Group

Save the Date….

Annual NJ HFMA Golf Outing

Thursday, May 9th, 2024, 1PM shotgun start

Mercer Oaks
West Windsor Township, NJ

Prizes and raffles!

More Information Available Soon!

Seeking Creative Content Writers

The HFMA New Jersey Chapter is seeking articles for the Garden State FOCUS magazine.

If you have a topic which would be of interest to the New Jersey healthcare industry, submit your article to njhfma@aol.com.

Deadline for Submission for Upcoming Issues

Winter 2023 - November 6, 2023
Spring 2024 - February 1, 2024
Summer 2024 - May 15, 2024
Institute 2024 - August 1, 2024