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new jersey chapter
Fall 2024 • vol 71 • num 1

garden state focus

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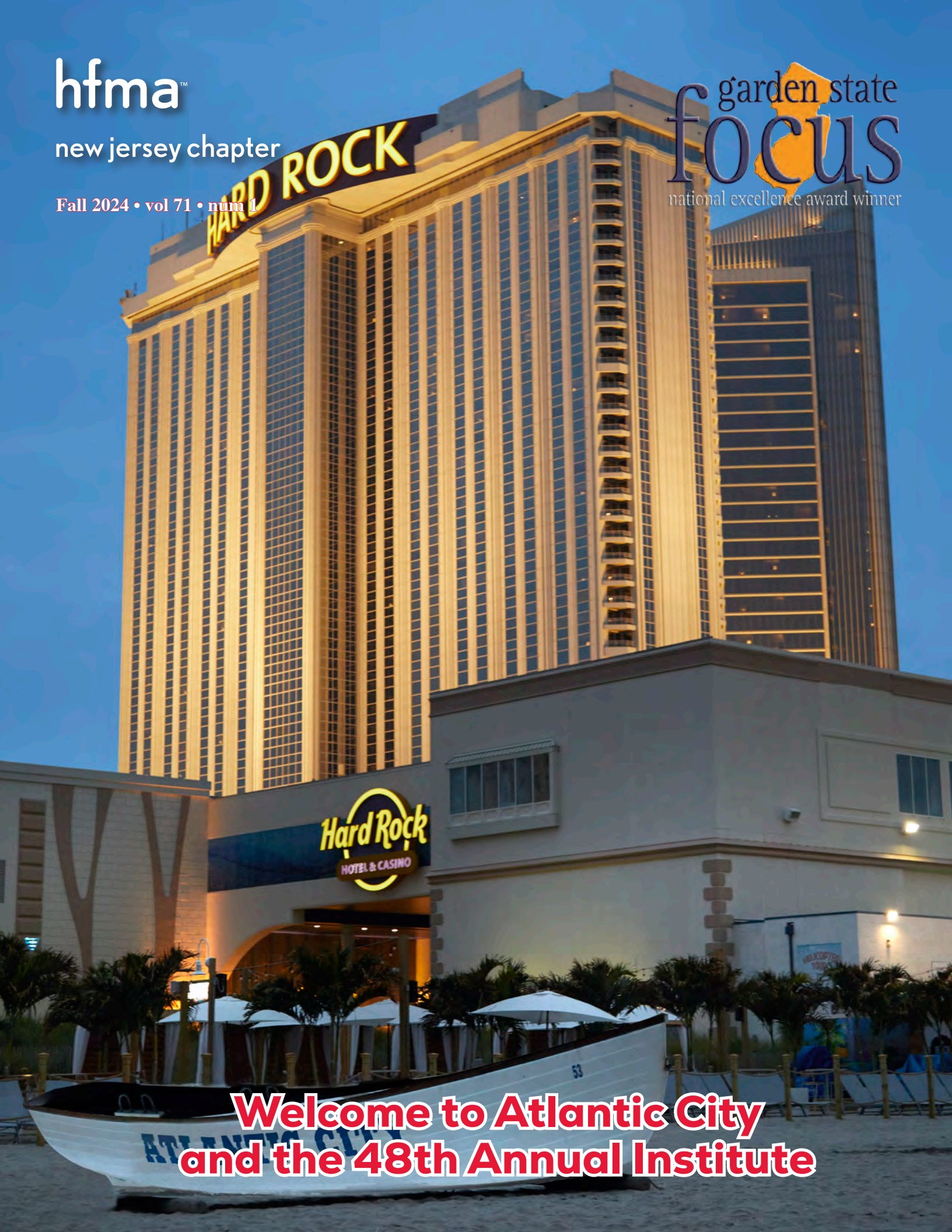

Welcome to Atlantic City and the 48th Annual Institute

New Jersey & Metro Philadelphia HFMA 48th Annual Institute

Revenue Cycle Round Table

October 10, 2024, 4:10 PM-5:25 PM
Seminole Ballroom

Moderator: Dennis Jones
Revenue Cycle SBO
Jefferson Health

Jean Bryll
VP, Revenue Cycle
RWJ Barnabas Health

Lynda Carbone
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Vanessa Mackay
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WMC Health

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Government Policy and Reimbursement Panel

October 11, 2024, 9:50 AM-10:40 AM
Seminole Ballroom

Moderator: Chris Czvornyek
VP, Finance and Strategy
HANJ

Cort Adelman
VP, Government Relations
Virtua Health

Kenneth Morris, Jr., MHA, MA
VP, External Affairs
St. Joseph's Health

Christine Stearns
Strategic Advisor
NJHA

C - Suite Panel

October 11, 2024, 10:50 AM-12:05 PM
Seminole Ballroom

Gui Valladares
Chief Financial Officer
Penn Medicine Princeton Health

Leigh Ehrlich
Executive VP and Chief Financial Officer
Main Line Health

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Color				
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Full Page	$ 1,100	$ 990 / $ 1,980	$ 935 / $ 2,805	$ 880 / $ 3,520
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DEADLINE FOR SUBMISSION OF MATERIAL

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

IDENTIFICATION STATEMENT

Garden State "FOCUS" is published 4 times a year by the New Jersey Chapter of the Healthcare Financial Management Association c/o Laura A. Hess, FHFMA, Chapter Administrator, Healthcare Financial Management Association, NJ Chapter, P.O. Box 6422, Bridgewater, NJ 08807.

OBJECTIVE

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

EDITORIAL POLICY

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

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

Laura Hess
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The President's View . . .

Maria Facciponti

I hope you all enjoyed a peaceful and relaxing summer. Fall is upon us - that means it is time for NJ & Metro Philly's Annual Institute in Atlantic City. We are proud to host this year's 48 annual institute which promises to be a grand slam event. This event provides a unique opportunity for industry leaders, experts, and professionals to engage in thought-provoking discussions, participate in hot topic education sessions, and create valuable relationships. This multi-day event's agenda, keynote speakers, and presenters promise to create a not-to-miss gathering that will set the tone for the impactful work we aim to accomplish together this year. Our dedicated Institute Committee has diligently worked to ensure that this year's event will be both informative and inspiring.

This year's charity is Breakthrough T1D. Type 1 diabetes (T1D) is a chronic autoimmune disease. This means that it doesn't go away. Anyone can be diagnosed with type 1 diabetes at any age, though it usually is diagnosed in childhood or adolescence. Join us in raising awareness and advocating for T1D research.

I commit to continue the legacy of NJ HFMA and foster an environment where all members are welcome to learn, contribute, and excel. Your active involvement is essential to the success of our organization, and I encourage you to participate with our committees, attend our education events, and enjoy our many networking opportunities planned throughout the chapter year. I am honored and proud to lead such a remarkable organization. Thank you for the opportunity.

Warm Regards,

Maria Facciponti, FMFMA, EHRC
President, NJ HFMA

From the Editor . . .

Jim Robertson

Editor's Letter for Annual Institute Edition:

As we head into the fall, all eyes are on the New Jersey & Metro Philadelphia HFMA 48th Anniversary Annual Institute!

This year, the Annual Institute moves to the opulent and exciting Hard Rock Hotel & Casino on the historical Atlantic City Boardwalk. To add to this excitement, the Annual Institute presents a star-studded line-up of speakers who will be providing interesting and informative programs on some of the most relevant and consequential topics affecting the healthcare industry. Here's a sneak peek of these program in this Edition of *Garden State FOCUS:*

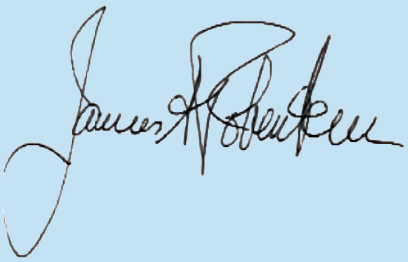
Alternative energy: Lynn Mucenski-Keck provides us with a detailed overview of the substantial tax credits available to non-profits that have invested in alternative energy projects while Emma Raymont explains how energy audits and efficiency improvements can assist healthcare facilities unlock financial and operational benefits.

Hospital Reimbursement: John Dalton provides a detailed 50-year historic retrospective on how New Jersey was the "Birthplace" of the DRG prospective payment system while Paul Croce and yours truly have summarized potentially one of the most momentous rulings of the United States Supreme Court which overrules Chevron deference which has been given federal agency action, subjecting agency decision-making (like CMS' reimbursement decisions) to closer judicial scrutiny.

Compliance and Operations: Craig Nesta provides some useful tips on how to leverage student workforce programs to address your organization's workforce challenges; Mark Janiszewski discusses the benefits of a single-vendor platform to maintain compliance with price transparency challenges; and Ronald Hirsch, MD educates us on the optimal hospital benchmark observation rate for proper patient placement.

The Communications Committee has curated these (and other) articles to provide you with, what we believe to be, an exceptional Edition of Garden State FOCUS magazine. And, if you are attending the Annual Institute, you'll receive a complimentary printed copy of Garden State FOCUS – the only printed copy available throughout the year, which will, no doubt, adorn coffee tables in households throughout the State until next year's edition. 😊

We hope you enjoy this Edition of Garden State FOCUS and look forward to seeing you all at the Annual Institute!



Thank you for joining us at the 48th Annual New Jersey and Metro Philadelphia Annual Institute – October 9-11!

Tara Bogart

By Tara Bogart

We are thrilled that you chose to join us at the 48th Annual New Jersey and Metro Philadelphia Annual Institute from October 9-11 at the Hard Rock Hotel & Casino in Atlantic City, New Jersey. While we're at a new venue this year, the exceptional educational content and networking opportunities you've come to expect will remain unchanged.

The conference begins with a welcome lunch on October 9 at 11:30 AM, with educational sessions starting at noon. The final session will conclude at 12:05 PM on October 11.

Education and Credits

Attendees will have the opportunity to earn up to 15 CPE credits through 28 sessions over the three days. The conference features 6 breakout sessions on Wednesday and Thursday, offering a choice of three to four different topics per session. Areas of focus include compliance, data analytics, financial reporting/tax, revenue cycle, and managed care/payer updates.

Featured Sessions

We have an exciting lineup of sessions featuring leaders from top local hospitals and health systems, including Saint Peter's University Hospital, Virtua Health, Inspira Health, RWJ Barnabas Health, Geisinger, Emerson Health, and St. Joseph Health System. Here are a few highlights:

- **Wednesday, 12:00 PM** – Summary of the Federal Fiscal Year (FFY) 2025 Centers for Medicare & Medicaid Services' (CMS) Final Rulings and Hot Reimbursement Topics with Tracey Roland, Principal at TPR Solutions LLC, and Thomas Morse, Manager – Finance and Regulatory Practice at TPR Solutions LLC.
- **Thursday, 9:00 AM** – Navigating the Nexus: Understanding A.I. Opportunities and Cybersecurity Threats in Healthcare presented by Gerry Blass, CEO of ComplyAssistant.
- **Thursday, 9:50 AM** – Charting the Course: Building a Sustainable Health Care Workforce for the State of New Jersey with Roselyn Feinsod, Partner at Ernst & Young, and Cathleen Bennett, President and CEO of the New Jersey Hospital Association.
- **Thursday, 11:00 AM** – Never Underestimate the Power of a Denial! featuring Jean Bryll, Vice President - Revenue Cycle at RWJ Barnabas Health, and Claire Skelley, Director of Denials and Appeals at RWJ Barnabas Health.
- **Thursday, 2:00 PM** – Lessons Learned from a Successful AI Implementation of Computer Assisted Coding with Beth Kushner, CMIO at St. Joseph's Health System.
- **Thursday, 3:10 PM** – Utilizing Educational Relationships to Address Workforce Challenges with Craig Nesta, Vice President COO Medical Group at Emerson Health.
- **Thursday, 4:10 PM** – Revenue Cycle Round Table. Dennis Jones will moderate a panel discussing the complexities of today's revenue cycle, featuring:
  - Vanessa MacKay, Network Vice President of Revenue Cycle at WMC Health
  - Leah Klinke, Executive Vice President of Revenue Operations, Hackensack Meridian Health
  - Lynda Carbone, AVP of Patient Financial Services, Inspira
  - Jean Bryll, VP of Revenue Cycle, RWJBarnabas Health
- **Friday, 9:00 AM** – 50 Years of Hospital Rate-Setting in New Jersey – A panel discussion led by John Dalton, Editor of The Three Minute Read and Healing American Healthcare Coalition.
- **Friday, 10:50 AM** – "C" Suite Panel – Don't miss hearing the latest updates in healthcare directly from "C" suite members from New Jersey and Pennsylvania.

Networking Events

- **Wednesday Night** – Charity Event: Join us for the annual charity event on October 9 from 5:30 to 7:30 PM. Enjoy heavy hors d'oeuvres, cocktails, wine, and beer while supporting Breakthrough T1D, an organization committed

to advancing research and advocacy for type 1 diabetes.

- **Thursday Night** – President's Reception: Attend the President's Reception on October 10 from 6:00 to 8:00 PM, featuring light hors d'oeuvres, cocktails, wine, and beer.
- **Thursday Night** – Late Night Event: Keep the party going on October 10 from 10:00 PM to 1:00 AM with cocktails, beer, wine, a DJ, and dancing.

Acknowledgments

We extend our sincere thanks to our sponsors and volunteers, whose support makes this event possible. A special thank you to the HFMA officers, committee chairs, and members for their dedication in organizing this engaging and educational conference. We look forward to seeing you there!

About the author

Tara Bogart is a seasoned revenue cycle professional with a career spanning two decades in the healthcare industry. Currently serving as a Vice President at PMMC, Tara is at the forefront of addressing critical issues related to revenue cycle management, managed care contract negotiations, pricing transparency, and charge master rate setting. Tara can be reached at Tara.Bogart@pmmconline.com.

Denim for T1D Heroes

By Maria Facciponti

Type 1 diabetes (T1D) is a chronic autoimmune disease. This means that it doesn't go away. Anyone can be diagnosed with type 1 diabetes at any age, though it usually is diagnosed in childhood or adolescence. T1D attacks the body's immune system and the insulin-producing cells in the pancreas. Insulin is an essential hormone that helps the body turn food into energy. People living with type 1 diabetes must take insulin by injection or insulin pump to survive. Living with T1D requires extra work, but with the right support and information, you or your loved one can lead a fulfilling, active life.

Breakthrough T1D's mission is to improve lives today and tomorrow by accelerating life-changing breakthroughs to treat, prevent, and ultimately, cure T1D and its complications. Always, we are guided by a single purpose: As we drive toward curing type 1 diabetes, we help make everyday life better for the people who face it.

Each year HFMA 's NJ and Metro Philadelphia Annual Institute Committee chooses a worthy charity to sponsor. This year we have chosen T1D.

HFMA is dedicated to raising awareness and advocating for T1D research. Join us in making a donation to our fundraiser by scanning the QR code. Please help us help T1D Heroes!

Mark Your Calendar

Holiday Pizza Networking

TBD, November? Date and location to be announced soon!

Annual PFS/PAS Joint Meeting
January 9, 2025 Pines Manor, Edison, NJ

Annual Institute
October 29-31, 2025 Hard Rock Hotel & Casino, Atlantic City, NJ

Watch for updates on all of these events, or visit the Chapter website at hfmanj.org

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New Jersey – Birthplace of DRGs

By John Dalton, FHFMA

John Dalton

Younger HFMA members are largely unaware of New Jersey's transformational role in America's healthcare reform efforts. For about a 20-year period from 1974-1993, much of the fundamental work in developing inpatient prospective payment systems happened right here. This article briefly highlights those developments, beginning with Medicare and Medicaid enactment.

In 1965, Title XVIII – Medicare (named for Canada's program of health care access for all) was enacted, assuring health care services for the elderly when they most need it, followed by Title XIX – Medicaid - enacted as a joint federal-state program to expand coverage for the working poor. In 1966, the country's first Medicare hospital claim was processed by Blue Cross of New Jersey (now Horizon) and delivered to Jack Farmer, CFO of East Orange General Hospital. It made the five o'clock news.

Budget Review (1968-74)

The expansion of access to healthcare services was accompanied by rapidly rising costs, and New Jersey was no exception. Initially, the state relied on a voluntary budget review process where hospitals submitted their budgets to an advisory committee appointed by the Commissioner of Insurance. The advisory committee reviewed the budget submissions and recommended rate ceilings to Blue Cross. However, costs continued to escalate rapidly.

In 1971, Republican Governor William Cahill signed the Health Care Facilities Planning Act, *N.J. Stat. Ann. §§ 26:2H-1 to 26:2H-26*, establishing a Certificate of Need planning process and authorizing the state Departments of Health and Insurance to jointly set inpatient Blue Cross and Medicaid payment rates. It also mandated participation of all hospitals in a budget review program.

Following enactment, the state delegated the budget review process to the Hospital Research and Education Trust, a subsidiary of the New Jersey Hospital Association. HRET reviewed the budgets and recommended per diem rate ceilings for Blue Cross and Medicaid. Two years in, the New Jersey Public Interest Research Group issued a blistering report, "Bureaucratic Malpractice," describing HRET's process as "the fox guarding the chicken coop," and the state was directed to take over the rate-setting process.

Per-Diem Rates (1975-79)

Newly-elected Democratic Governor Brendan Byrne's cabinet included James Sheeran as Insurance Commissioner and Dr. Joanne Finley as Commissioner of Health. Sheeran had been Byrne's high school classmate, mayor of West Orange and chair of "Republicans for Byrne." He also was a decorated World War II veteran and a consumer advocate. Joanne Finley had been serving as Director of Public Health in New Haven at the time she was appointed to the Byrne cabinet. Previously, Dr. Finley was Vice President for Medical Affairs with Blue Cross of Philadelphia and headed health planning in that city from 1968 to 1972.

Both commissioners saw eye-to-eye and, following the blistering NJPIRG report, took on the hospital rate setting challenge. The state issued a request-for-proposals for a contractor to develop and implement an inpatient hospital rate-setting system. Given their experience in doing so for the state of Maryland, Haskins & Sells (now Deloitte) was selected to develop 1975 inpatient rates for New Jersey's hospitals. John Dalton was assigned as Project Manager to get it done, reporting to Sister Cathleen Maloney, SC, CPA, Chief of the Rate Setting Program.

Sister Cathleen was the first member of her order to become a CPA and was Controller at St. Elizabeth's Hospital before joining the Department of Health. She reported to Assistant Commissioner John B. Reiss, who had been a Health Economics Professor at Stockton State College before joining the Department.

The consulting contract was finalized in early September and, in a fast and furious four months, the project team:

- Recruited and trained seven rate analysts (Gene Arnone, Mike Dively and Jim Hull; then Joe Lario, Chuck Lydon, George Popko and Al Rabin).
- Designed cost-reporting worksheets for the Standard Hospital Accounting and Rate Evaluation System (SHARE) that hospitals would use to report functional costs for about 30 cost centers.
- Developed a classification system for peer groups

of hospitals by type (major teaching, minor teaching and nonteaching community hospital) and location (inner city, urban, suburban and rural). At the time, New Jersey had one county classified as rural – Hunterdon. Specialized and rehabilitation hospitals continued to be subject to budget review.

- Promulgated regulations describing the rate-setting process, and included an appeal option for providers dissatisfied with their Blue Cross and Medicaid prospective pre diem payment rates. The regulations were challenged by NJHA as violating the Administrative Procedures Act's comment period requirements, but compliance with the APA would have left hospitals without updated payment rates well into 1975.
- Worked with NJHA and NJHFMA to recruit a panel of hospital CFOs to advise on reclassification recommendations from responsibility accounting to functional reporting. They included Jim Carroll from Morristown Memorial Hospital, Tom Dalton from Overlook Hospital, Jack Farmer from Hackensack Hospital and Keith McLaughlin from Perth Amboy General Hospital.
- Wrote and issued a twice-monthly "Health & Insurance Newsletter" to update hospitals on progress.
- Conducted on-site briefings and training sessions in each of the state's four regional planning districts.

By late November, reports began flowing in from hospitals. They were desk-checked by the rate analysts for accuracy and completeness, then either sent back to the hospital for corrections or passed on to data entry. System testing began in earnest, and the rate analysts were able to begin reviewing results and verifying per diem inpatient payment rates for their assigned hospitals.

By mid-January 1975, inpatient per diem payment rates were set for New Jersey's 108 acute care hospitals. It came as no surprise that most of the hospitals were not pleased with the results. Most hospitals appealed their initial rate determination, arguing that the system did not adequately reflect the uniqueness of their service area and patient mix. NJHA advocated for changes to improve the system's fairness. A number of changes were made to the SHARE regulations for 1976, and the Department of Health began to consider other approaches to rate setting.

All-Payor DRGs (1980-89)

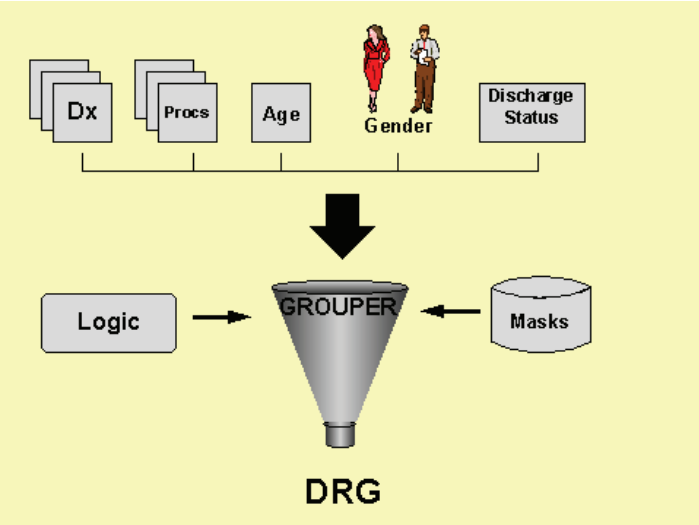
As New Haven's Director of Public Health, Dr. Finley had become familiar with work being done at Yale University to use clinical data about a patient's condition to predict how long a patient would stay in the hospital. She recognized that this approach to utilization management might also provide a basis for rate setting. Professors John Devereaux Thompson and Robert Fetter were invited to make a presentation of their work at the Department of Health. I was at the presentation and still vividly recall Thompson stating, "If General Motors can cost out cars, hospitals can cost out patients." Having recently completed design of a cost accounting system for a major textile manufacturer, Thompson's statement made sense to me

Commissioner Finley agreed that a patient-centric approach to rate-setting on a per case basis had the potential to be fairer than costs per diem that did not adequately reflect a hospital service area's epidemiology and patient case mix. New Jersey then applied for a Medicare Sec. 1115 waiver for a demonstration project to implement an inpatient payment system for all payors based on Diagnosis-Related Groupings (DRGs).

In 1976, Michael Kalison was retained to head up the demonstration project. A recent graduate of the Law School at the University of Pennsylvania, he had served a clerkship with the New Jersey Supreme Court. In early 1977, Jo Surpin joined as a case-mix analyst and later as Assistant Project Manager. With a $4 million dollar grant, the Medicare waiver and enabling legislation (Chapter 83, which also established the Hospital Rate Setting Commission to set and adjust the schedule of reimbursement rates used by New Jersey hospitals), New Jersey designed and implemented the country's first prospective payment system where payment per inpatient case was based on illness primarily as defined by specific ICD-9 diagnosis and procedure codes.

Clinical information was merged with other information, including patient demographic data, to be "grouped" into the applicable DRGs (see Exhibit 1). Initially, there were 383 DRGs in 25 major diagnostic categories.

Hospitals had advocated for inclusion of all uncompensated care in the prospective payment rates, both



charity care (can't pay) and bad debt (won't pay). Their insistence on inclusion of bad debt ultimately proved to be a fatal error.

Joe Morris had joined the Department of Health as a rate analyst in 1977, and when Mike Kalison left, replaced him as Project Manager in March 1979, nine months before the first group of hospitals transitioned from SHARE to DRGs. Dr. Bruce C. Vladeck had succeeded John Reiss as Assistant Commissioner of Health. Vladeck subsequently served as Administrator of the Health Care Financing Administration (now CMS) from May 1993 to September 1997.

Over a three-year period (1980-82), New Jersey's acute care hospitals transitioned from SHARE to DRGS:

- 26 hospitals pioneered the transition in 1980;
- 36 hospitals joined in 1981, bringing the total to 62;
- 1982 - All 96 hospitals were phased into DRGs.

At the federal level in 1982, the Tax Equity and Fiscal Responsibility Act (TEFRA) modified the Section 223 Medicare hospital reimbursement limits to include a case mix adjustment based on DRGs. In 1983 Congress amended the Social Security Act to include a national DRG-based Prospective Payment System for all Medicare patients (2). The pioneering efforts of the New Jersey demonstration project were being adopted nationally.

The Medicare waiver would continue in effect so long as the Medicare program spent less than it would have under its new Prospective Payment System. Although payment per case incentivized hospitals to focus on reducing length of stay, inclusion of bad debt as an element of allowable cost eventually led to New Jersey's costs exceeding what Medicare would have paid and the 1989 loss of the Medicare waiver.

All but Medicare DRGs (1989-93)

New Jersey attempted to continue with an "all but Medicare" DRG system, adding a state-mandated surcharge to cover uncompensated care, Medicare shortfall and prior years' payment shortfalls. In 1990, the United Wire, Metal & Machine Health & Welfare Fund filed suit against 14 New Jersey hospitals contending that they need only pay the actual charges on inpatient hospital bills, exclusive of state-mandated surcharges and markups (3).

A total of 14 unions "piggy backed" on the original suit and 70 hospitals were named as defendants along with the state and the Commissioner of Health. They argued that, as self-insured employer funds protected by the Employee Retirement and Income Security Act of 1974 (ERISA), they were exempt from paying surcharges that result from state regulations. They contended that mark-ups such as adjustments for uncompensated care, Medicare shortfalls and other cost shifts represented hidden and illegal taxes.

When District Court Judge Alfred M. Wolin ruled for the plaintiffs, the May 28, 1992, banner headline in the Star-Ledger read, "Judge derails hospital rate system." The decision in favor of the ERISA plans was appealed.

However, given the uncertainty of the appeal's likelihood of success and concerns about the imminent expiration of the Health Care Trust Fund, the legislature enacted the Health Care Reform Act of 1992 (HCRA-92) that, among other actions,

- Diverted $1.6 billion, over three years, from the Unemployment Insurance Fund to finance charity care;
- Expanded charity care eligibility criteria and provided that charity care be paid at Medicaid rates;
- Continued the Hospital Rate Setting Commission for a one-year transition to a deregulated system;
- Eliminated DRG billing for non-federal payors and enabled hospitals to bill charges; and
- Imposed a cap on hospital revenues for 1993.

The last-minute addition of the revenue cap provision placed many hospitals in a threatening financial condition rather than having one final year (1993) to recover prior years' undercollections. Nonetheless, 1993 marked the dawn of deregulation for New Jersey's hospitals.

In an ironic footnote, the Third Circuit Court reversed Judge Wolin's decision in April 1993. The 2-1 ruling supported the position taken by the Department of Health and the New Jersey Hospital Association that ERISA did not preempt the Chapter 83 rate-setting system. The appeals court found that New Jersey's rate-setting system was not intended to regulate the affairs of ERISA plans. Rather, the uncompensated care add-ons, Medicare shortfalls and discounts to certain payers were all part of doing business.

Frank Ciesla, who argued the case for NJHA, stated "While this is clearly a win, no new ground was broken with this decision. If you're looking for new insight into ERISA applicability, you won't find it here." Unfortunately, the decision came too late as the sun already had set on New Jersey's innovative experiment that became the template for Medicare's Inpatient Prospective Payment System, still in use today.

Dr. Finley's Vision Transformed Hospital Care

Ten years ago, an article in the Annals of Internal Medicine took a retrospective look at 30 years of DRGs. Author Kevin Quinn argued that Medicare paying hospitals by diagnosis-related group was "the most influential innovation in the history of health care financing" (4). Quinn stated that "The strong incentives were revolutionary in their impact." The change from cost reimbursement to prospective payment incentivized hospitals to become more cost-effective. His

literature survey concluded that none of the worst fears about adverse effects on patients were realized.

And it all began right here in the Garden State.

References:

[1] Hospital Rate Setting and Patient Access Under the New Jersey Hospital Rate Setting System, by Glenn Melnick, Joyce Mann and Carl Serrato, the RAND Corporation, September 1988

[2] Design and development of the Diagnosis Related Group (DRG), Centers for Medicare and Medicaid Services, PBL-038, October 2019

[3] United Wire, Metal & Mach. Health & Welfare Fund v. Morristown Memorial Hosp., 995 F.2d 1179, 1993

[4] After the revolution: DRGs at age 30, by Kevin Quinn, Annals of Internal Medicine, March 2014

About the authors

John J. Dalton, FHFMA serves as Senior Advisor Emeritus at BESLER and Editor of the Three Minute ReadTM, the twice-monthly newsletter of the Healing American Healthcare Coalition. A Past President of the New Jersey Chapter and National Board member, he was the 2001 recipient of the Frederick C. Morgan Award for Individual Lifetime Achievement. The New Jersey Hospital Association named him as its 2017 Hospital Trustee of the Year.

New Jersey Healthcare Financial Management Association 2023-24 Chapter Awards Listing

President's Award
Michael McKeever FHFMA, CPA
Maria Facciponti, EHRC, CRCR, FHFMA

Founders Merit Award - BRONZE
Belinda Puglisi
Fatimah Muhammad, FHFMA, CRCR, CSPR, CSBI
Hanna Hartnett, FHFMA
James O'Connell
John Byrne

Founders Merit Award - SILVER
Nicole Rosen

Founders Merit Award - GOLD
Heather Stanisci
James Robertson, Esq

Medal of Honor
Brian Herdman
Amina Razanica, FHFMA

Member in a Non-Leadership Position
Ari Van Dine

The Life and Death of *Chevron* Deference and the Future of Administrative Law

James A. Robertson

Paul L. Croce

By: James A. Robertson and Paul L. Croce

For four decades federal agencies have been given wide latitude to adopt and interpret regulations implementing statutes within their areas of expertise. This latitude has been viewed with both praise and scorn. On the one hand, many have argued that, due to their expertise, agencies are in the best position to determine how Congress intended the statutes it has adopted to be implemented. Conversely, others have argued this latitude has taken the power to make and change laws away from the legislative branch and transferred it to unelected members of the executive branch (i.e., the agency). While this debate will surely continue, a recent decision by the Supreme Court of the United States has changed the playing field significantly impacting the role of federal agencies in our society.

A. *Chevron* Deference is Born

On June 25, 1984, the Supreme Court of the United States issued its decision in *Chevron U.S.A. v. Natural Resources Defense Council*[i] establishing the legal doctrine commonly referred to as "*Chevron* Deference." That doctrine required courts to defer to a regulatory agency's interpretation of the statutes it administers if those interpretations were "permissible." The doctrine was a significant departure from the traditional judicial approach of independently examining each statute to determine its meaning.

Under *Chevron*, a court reviewing an agency's interpretation of a statute was required to engage in a two-part analysis. First, the court had to determine whether Congress had directly spoken on the issue. If Congress had done so, courts would apply the statute as directed by its plain language. However, if the statute was silent or ambiguous, courts were required to defer to the implementing agency's interpretation of the statute if it was based on a permissible construction of the statute even if that interpretation was different than, or even contrary to, what the court would have ruled in the absence of agency guidance.[ii]

The Supreme Court explained in a later decision that *Chevron* rested on "a presumption that Congress, when it left ambiguity in a statute meant for implementation by an agency, understood that the ambiguity would be resolved, first and foremost, by the agency, and desired the agency (rather than the courts) to possess whatever degree of discretion the ambiguity allows."[iii] As a result, for forty years, the regulated public could only truly challenge an agency's interpretation of a statute by demonstrating that the agency's interpretation was directly contradicted by the plain language of the statute.

B. The Death of *Chevron* Deference

That all changed on June 28, 2024, when the Supreme Court of the United States issued its decision in the cases of *Loper Bright Enterprises, et al. v. Raimondo, et al.*, and *Relentless Inc. et al. v. Department of Commerce, et al.*, which explicitly overruled Chevron.[iv] The *Loper Bright* Court specifically held that "[c]ourts must exercise their independent judgment in deciding whether an agency has acted within its statutory authority."[v]

In analyzing the issue, the Supreme Court provided a history of the judiciary's role in interpreting statutes beginning with the Federalist Papers, through the Court's early decision in *Marbury v. Madison*, the rapid expansion of the administrative process which took place during the New Deal era, and ultimately the adoption of the Administrative Procedures Act (APA).[vi] That history demonstrates that while courts should provide "due respect" to the executive branch's interpretation of federal statutes, no specific deference to that interpretation was required, or expected, prior to the *Chevron* decision.[vii]

While this history helped form the Supreme Court's decision, its primary focus was on the incongruence between

the APA and the holding in *Chevron*.[viii] Pursuant to the APA, a "reviewing court" is required to "decide all relevant questions of law" and "interpret . . . statutory provisions."[ix] The Court found that the APA, consistent with constitutional mandates, requires courts to exercise independent judgment to determine the best interpretation of the statute, and that this obligation could not be reconciled with *Chevron's* directive to defer to "permissible" agency interpretations. As the Court noted, "[i]n the business of statutory interpretation, if it is not the best, it is not permissible."[x]

Ultimately, the Court overruled *Chevron*, finding that it "was a judicial invention that required judges to disregard their statutory duties."[xi] Under the new standard of review, "court's must exercise their independent judgment in deciding whether an agency has acted within its statutory authority, as the APA requires."[xii] While the Court acknowledged that "[c]areful attention to the judgment of the executive branch, may help inform that inquiry,"[viii] that judgment need not be provided any more significant weight than other rules of statutory interpretation.

The Court further acknowledged that Congress may delegate authority to agencies in the statutes it adopts, and where it has done so, within constitutional limits, courts must respect that delegation, while ensuring that the agency acts within it.[xiv] In such circumstances, courts must fix the boundaries of the authority delegated and determine whether the agency, acting within the scope of that delegation, engaged in "reasoned decision making."[xv] However, in the absence of such a delegation, courts must exercise their own independent judgment when interpreting statutes.

C. The Future of Administrative Law After *Loper Bright*

The *Loper Bright* decision represents a seismic shift in how courts will review agency action. Courts are no longer bound by the decisions of the implementing agency. Rather, courts are free, and indeed obligated, to determine for themselves what Congress intended when it adopted the statute.

The decision will likely lead to an influx of litigation challenging agency action, as the arguments raised by the regulated public regarding the best interpretation of the statutes implemented by the agencies will be placed on equal footing with the interpretations asserted by the agencies.

Nevertheless, it remains unclear how lower courts will implement the holding in *Loper Bright*. Given that the Court acknowledged that careful attention should be given to the judgment of the executive branch, an agency's interpretation will remain part of the analysis when determining the best reading of a statute. Similarly, the Court acknowledged that Congress can delegate authority to agencies, and when that has been done, courts should respect that delegation. Given the variety of judicial philosophies amongst the members of the federal bench, it is unlikely that lower courts will consistently provide the same level of attention to the judgment of the executive branch or apply a standardized test for determining when Congress has delegated authority to an agency.

Accordingly, the *Loper Bright* decision may, at least in the short term, be a double-edged sword for the regulated public. While there will be additional opportunities to challenge agency action, inconsistent decisions by the lower courts may cause confusion regarding the appropriate application of a statute, with federal statutes and regulations being interpreted in different ways depending on what part of the country one is located. Although such potentially conflicting decisions are likely to eventually be resolved by the Supreme Court, until that has occurred, it may bring uncertainty and continuous change to the regulated public.

About the Authors:

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

Paul L. Croce is Counsel in the firm's Healthcare and Litigation Departments, where he concentrates his practice in the areas of healthcare litigation, and Medicaid, Charity Care and Disproportionate Share Hospital reimbursement matters. He can be reached at at pcroce@greenbaumlaw.com.

i *Chevron U.S.A. v. Natural Resources Defense Council*, 467 U.S. 837 (1984).
ii Id. at 842-843.
iii *Smiley v. Citibank (South Dakota), N.A.*, 517 U.S. 735, 740-741 (1996).
iv *Loper Bright Enterprises, et al. v. Raimondo, et al.*, 144 S.Ct. 2244 (2024)
v Id. at 2273.
vi Id. at 2257-2263.
vii Id.
viii Id. at 2263-2270.
ix Id. at 2261; 5 U.S.C. § 706.
x 144 S.Ct. at 2266.
xi Id. at 2272.
xii Id. at 2273.
xiii Id.
xiv Id.
xv Id. at 2263.

ARE YOU FEELING STRESSED?

HFMA NJ is introducing a new column in the Garden State FOCUS Magazine

STRESS LESS & THRIVE MORE: TIPS FROM COACH LISA HAMMETT

Have a question or need some advice? Email info@lisahammett.com to be featured in the column. Participants will remain anonymous.

Stress SOS: Solutions with Coach Lisa

Are you stressed? Feeling stuck? Frustrated? Needing support? Ask Coach Lisa.

Lisa Hammett

1. How do I add more hours to my day? LOL! No, seriously! It can be very stressful and overwhelming when we feel there are not enough hours in the day to complete what we need to accomplish, especially when we are being pulled in multiple directions. Time blocking can be very effective.

Scheduling one hour blocks of time to complete tasks, prepare for meetings, or take a self-care break, can be very effective. For this to work, the time must be protected. Block your calendar and tell your team, colleagues, and family, etc. that you will be in a meeting for one hour. Silence your phone and notifications on your computer. It's amazing what can be accomplished in one hour of uninterrupted time.

2. How can I reduce my stress at work when I don't have time to take a break?

Taking mental fitness breaks throughout the day can reduce stress and improve focus.

The next time you go to the bathroom, spend a couple minutes focusing on your breath. Breathe in slowly for a count of four, hold the breath for a count of four, and exhale slowly for a count of four.

When you're washing your hands, focus on how the warm water feels as you rub your hands together.

When you leave the bathroom, notice how your feet feel on the floor as you walk back to your desk/office.

These micro-meditations will slow your heart-rate and take the focus off the stress and overwhelm you've been feeling.

3. My boss does not support me or his/her team. It is really frustrating and affecting my morale and the morale of the team. How do I decide if it is time to look for a new job?

Feeling unsupported at work is very demotivating. Have you tried to have a conversation with your boss regarding what you specifically need? If so, and there has been no support, it may be time to escalate the situation.

Does your boss's supervisor have an open door policy where you can share your concerns? If so, having a confidential conversation may be beneficial. If you feel uncomfortable having this discussion, and/or you feel it will reflect negatively on you, does your organization have an anonymous support line where you can share your concerns?

If you have a mentor or a trusted colleague you can confide in, this may give you a different perspective. It's imperative that this individual be objective to your situation.

Lastly, if you and your teammates are being treated unfairly, this is an HR conversation.

If you can honestly say that you have exhausted all avenues to improve your situation, it may be time to leave the organization or look for other areas within your organization that might be a better fit.

4. I cannot seem to find time for myself. My job is very demanding. I have 3 small kids and a parent that is having medical issues. In addition, my husband travels for work. The pressure around me is very stressful. Any suggestions?

Firstly, I want to commend you for juggling a demanding job while raising a family and dealing with an aging parent. That can be very stressful. Recognizing that you need time to yourself is a huge step to preventing burnout and prioritizing your health and wellbeing.

When you're pulled in a million directions it can be helpful to put your commitments on a month at a glance calendar, so you can visualize blocks of time that you have available.

Add all commitments by day (i.e. work, childcare, medical appointments, etc.). Next, on a daily calendar, break down commitments into time blocks. Identify time blocks where you can schedule self-care. If you can schedule daily self-care practices at the same time each day, this consistency will help you develop the habit. If that's unrealistic, schedule self-care breaks each day, during available times. Some days it may be several 15 minute breaks throughout the day. On other days, it may be an hour break.

Block time for self-care breaks as you would a work meeting or a doctor's appointment. This goes for lunch breaks as well. Alert co-workers and family members when you are unavailable. Post your calendar on your refrigerator. Block your work calendar.

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What's the Benchmark Observation Rate?

By: Ronald Hirsch, MD, FACP, CHCQM, CHRI

Ronald Hirsch

Hardly a week goes by when I am asked either what a hospital's observation rate should be or what a hospital can do to lower their observation rate because it is felt to be "too high." So what is the right rate and is your rate too high?

First, you have to be sure you are comparing apples to apples. How is the observation rate determined in each institution? Observation is often a catch-all for all patients who are staying in the hospital but are not admitted as inpatient. In reality, observation is a specific service ordered on outpatients who require a period of monitoring in the hospital beyond the emergency department evaluation or after routine recovery from an outpatient surgery. Observation is not to be used for the routine recovery patient who spends the night in the hospital, for the patient who cannot get a ride home or for the patient that is dropped off by the family because they cannot take care of their loved one any longer.

The observation rate also depends on how it is calculated. Are patients who receive observation services but are subsequently admitted as inpatient counted in the rate? Is the rate the number of observation patients compared to all patients who spend a night in the hospital (inpatient and outpatient) or compared to all inpatients? Does the rate look solely at fee-for-service Medicare, where the observation rules are clear, or does it include Medicare Advantage and commercial patients, where the differentiation between observation and inpatient is often determined by contractual terms or at the whim of a reviewer who may be incentivized to deny as many inpatient admissions as possible?

Observation is also not always a bad thing. The current ambulatory payment classification (APC) for observation services provided to patients where the billing requirements are now pays $2,231 (C-APC 8011) and if observation services are provided efficiently with a minimum of incidental services provided, the reimbursement can exceed the actual costs of providing that care. Reimbursement for many of the lower weighted diagnosis-related groups (DRGs) barely exceeds that amount so it may be possible to make money on observation and lose money on inpatient admissions.

The Two Midnight Rule draws a bright line at two midnights. Patients in medically necessary hospitalizations should not pass two midnights without being admitted as inpatient. Many hospitals have not embraced this and keep patients in observation past the second midnight despite the presence of medical necessity for hospital care. These hospitals are losing the opportunity to convert an outpatient APC payment into a DRG payment.

Likewise, patients who are expected to require under two midnights should not be admitted as inpatient except for the exceptions outlined by CMS in their guidance. Some hospitals have adopted the philosophy that the payment for observation services is inadequate and they therefore feel justified in admitting as inpatient patients who have passed two midnights due to convenience or social factors, rationalizing it by noting that the short stay inpatient admission audits are limited to patients whose length of stay is one midnight. That means these admissions will never be audited so no one will realize that the medically necessary portion of the admission was limited to one day. This is anathema to the concepts of compliance and should be avoided.

Because of the many variables in defining and measuring and observation rates, it is better to set a best practice policy and aim to meet or exceed that policy in order to achieve your hospital's benchmark observation rate. The best practice for observation services is the modestly named "Hirsch's Law," which states that if every patient requiring the use of a hospital bed is reviewed by case management for proper admission status, with the use of a secondary physician review as appropriate, and every patient is placed in the right status, and observation services are only ordered on the patients where observation services are appropriate per regulations, and every patient goes home as soon as their need for hospital care has finished and every patient who requires a medically necessary second midnight is admitted as inpatient, then your observation rate is at your benchmark.

How does one meet the requirements of Hirsch's Law? Adequate resources dedicated to utilization review are critical. The utilization review staff needs to be available when patients are presenting to the hospital for further care to assist physicians in making these decisions. Many hospitals provide full staffing on weekdays but only have limited staff available on evenings and weekends. Unless the emergency department closes on Friday at 5 pm and reopens on Monday at 7 am, there needs to be UR staff available off hours. It should also be conveyed to physicians that these are purely payment issues so they do not get defensive and resist asking for help; they are not being told what antibiotic to choose or what specialist to consult.

Because it is felt that processes that cannot be measured cannot be managed, rather than comparing observation rates between hospitals and subjecting yourself to incorrect assumptions, there are several measures that can be used. First, as noted, keep your data clean by only looking at Medicare fee-for-service patients. Including other payers will taint your data depending on your payer mix and the rules used by the other payers, or lack thereof. Hospitals should also look at the length of stay for medical patients receiving observation services and work to optimize that. If you want to look at observation services after outpatient surgery, keep that data separate from medical observation; the two cannot be compared because of the fundamental difference in their care.

If you are going to compare your observation length of stay to other hospitals, be sure that they are not including observation provided routinely to patients after an outpatient procedure (often incorrectly used to enable the bed control system to assign the patient a bed for overnight use) or observation care provided as a courtesy. Likewise, your medically necessary observation hour counting and billing should end when medically necessary hospital care has ended. "Observation" care is by definition only care that is clinically appropriate. If a patient remains in the hospital for 4 hours or even overnight because of lack of transportation home, that care should be billed as HCPCS A9270 and not as observation hours.

Ensure that tests needed to determine an observation patient's stability for discharge, such as cardiac stress tests and magnetic resonance imaging (MRI), are prioritized over routine tests, that the physicians responsible for interpreting those tests, such as radiologists and cardiologists, are available when the tests are completed, and that the results are expeditiously relayed to the treating physician for a disposition decision. It would be relatively easy to break this down by diagnosis, service, day of week and physician to target quality improvement efforts.

Next, look at the number of patients receiving observation services who are hospitalized more than two midnights to determine if any of these had medical necessity for hospital care beyond the second midnight and therefore should have been admitted as inpatient. And finally take a close look at all inpatients who spend only one midnight to ensure that they truly met one of the specified exceptions and that the documentation supports that exception.

This deep dive into your data will provide you with accurate, measurable, and actionable information to ensure you are placing patients in the right status, optimally providing their care, receiving the reimbursement you deserve and avoiding a surprise visit by an auditor or the Inspector General.

About the author

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

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The key to ensuring you have protected self-care time, is to establish healthy boundaries. Say no to commitments that are less important and prevent you from scheduling daily self-care. When saying no, don't apologize or provide a dissertation as to why you are unavailable. A simple, "I am already committed," will suffice.

About the author

Lisa Hammett is an accomplished transformational and TEDx speaker, an international best-selling author, a Certified Positive Intelligence PQ Coach, and a wellness expert, helping stressed and burned-out Leaders and Organizations in Healthcare and HR create work/life balance to increase productivity, profitability, 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. Submit your questions to Lisa at info@lisahammett.com.

Utilizing Relationships in Education to Address Workforce Challenges

Craig Nesta

By: Craig Nesta, JD, MBA, MS, FHFMA

The healthcare sector is facing a significant exodus of employees in key clinical and administrative positions, including front-line and management roles, and the strained applicant pool further exacerbates the issue. The convergence of open positions and workforce shortages among several disciplines, including healthcare finance, demands dynamic workforce strategies to address the challenges of recruitment and retention of new and existing employees. The perfect storm of growth in the sector, declining applicant numbers, and personnel leaving vital positions has resulted in structural inefficiencies and a discernible effect on several healthcare organizations.

To help navigate these challenges, healthcare organizations should consider adopting alternative solutions that go beyond traditional recruitment and retention strategies. One such opportunity is the strategic development and implementation of student workforce programs, which may include internships and administrative fellowships. These programs not only provide students with valuable hands-on experiences, but also offer healthcare organizations a pipeline of motivated, versatile employees capable of contributing across various departments.

The Strategic Importance of Student Workforce Programs

Student workforce programs are an extremely significant asset to healthcare organizations, particularly in the current labor market, which is exceedingly competitive in an environment described as the "Great Resignation." Complementing an organization's existing recruitment and sourcing tactics with a program that focuses on students at all levels of educational attainment will aid in the success of an organization's human resource function by broadening the available workforce to perform much needed positions in a healthcare setting. These programs allow organizations to nurture students with a strong predisposition to healthcare that are aligned with the organization's mission, vision, goals, and objectives.

As an example, the students who take part in these programs frequently undertake collaborative projects that are designed to address important operational challenges and offer solution-based ideas from a different perspective. Furthermore, the significance of these programs goes beyond the duration of the students' term; frequently, students who are already trained may transition into permanent roles within the organization, carrying with them an acquired understanding of the organization's processes and culture learned from their student experience. Additionally, essential vacancies are filled with individuals familiar with the operations of the organization; thus, reducing the learning curve and affording quicker contributions as a member to their respective team.

Building a Successful Student Workforce Program

Establishing a robust student workforce program requires thoughtful planning and alignment with the organization's broader strategic human resources objectives. It begins with a thorough assessment of the organization's human resource needs, both current and future. This includes identifying areas where support is most needed and determining the types of experiences that will best prepare students, while meeting the current and potential future needs of the department/organization.

As part of the developing of a student workforce initiative, there any many resources available that offer guidance. For instance, collaborating with organizations like The National Council on Administrative Fellowships (NCAF), could be helpful when establishing an administrative fellowship program by linking prospective fellows with healthcare organizations. Other organizations that could be helpful when founding a program may include the Association of University Programs in Health Administration (AUPHA) and the Commission on Accreditation of Healthcare Management Education (CAHME).

The Long-Term Impact of Student Workforce Programs

In the post-pandemic era, the healthcare industry faces complex, multi-dimensional challenges that require innovative and sustainable solutions. Student workforce programs represent a forward-thinking approach to workforce development, one that addresses both immediate staffing needs and long-term succession planning.

These programs build a pipeline of future employees and

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•Focus on Finance•

How to Manage the Hospital Cash on Hand Crisis

James Trubenbach-Byrne

By James Trubenbach-Byrne

According to an S&P Global Ratings report released on August 7, median days cash on hand for U.S. hospitals and health systems dipped to a 10-year low. While the upper half of U.S.-based nonprofit acute healthcare providers reported an average of 292 days, the concern is with those in the lower half, who reported 128 days on average. As a result of the lower cash on hand, the report noted that an uptick is expected in borrowing activity for many organizations in 2024.

Q: What is cash on hand and why does it matter?

A: The pressure on cash on hand continues in 2024, with elevated operating expenses coupled with limited operating revenue growth. Cash on hand is essential for hospitals and health systems' long-term success, as it is vital for investment in new or the maintenance of specialized equipment that can generate higher revenues. It's also needed for investment in higher-margin specialty practices or to support lower-margin services that are fundamental to the communities served.

Q: How can I improve cash on hand for my organization?

A: One way to improve cash on hand is to evaluate the revenue cycle for potential leakage. At Withum, we offer various solutions to capture this leakage. A full revenue cycle assessment is a place to start. With a focus on workflow, processes, and technology, we can provide recommendations and observations of areas that need improvement to achieve industry best practices. Another opportunity is denial management. Every payor denies for different reasons depending on the service being provided. It is critical to understand these at a granular level and to create process and workflow changes to minimize the number of denials and immediately provide a positive impact on cashflow. Lastly, we look at underpayments, specifically for Medicare, as you are allowed a four-year look back to adjust a billed claim if it was not billed accurately, and there is an opportunity to file an adjusted claim that will provide additional cashflow and assure you are being paid accurately for the service that was provided.

About the author

James Trubenbach-Byrne is Senior Manager at Withum and can be reached at jbyrne@withum.com.

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potential leaders who are ready to take on roles that are crucial to the organization's success going forward, in addition to filling important shortages in the workforce. Healthcare organizations can position themselves to not just survive, but thrive by incorporating student programs in their human resource arsenal.

In summary, championing student programs including, but not limited to, internships and fellowships provide the organization with a versatile and motivated workforce capable of advancing the goals of the organization across several key departments and disciplines within varied healthcare organizations.

About the author

Craig Nesta is currently Vice President, for Emerson Health and COO of Emerson Practice Associates and leads finance and operations for the multi-specialty employed medical group. Craig is also the Fellowship Director for the Emerson Health Administrative Fellowship Program. Prior to joining Emerson Health, Craig has held leadership positions at Brigham and Women's Hospital, Children's Hospital Boston and Dana-Farber Cancer Institute.

Craig has served multiple terms on HFMA National Advisory Councils and currently serves on the Board and Treasurer of the MA/RI HFMA Chapter.

Craig can be reached at cnesta@emersonhosp.org.

A Well-Oiled Machine: Departments Working Together for Better Reimbursement

A Conversation with Reimbursement Professionals

Christine Gordon

Angela Kaminsky

By: Christine Gordon & Angela Kaminsky

Hospital reimbursement is a multifaceted process that involves meticulous reporting requirements and continuous audits. While the hospital reimbursement department plays a crucial role in ensuring regulatory compliance, as well as enhancing and preserving reimbursement, the effectiveness of this department is dependent on decisions made by various departments within the health system. To that end, education, communication, planning and leadership are critical to hospital systems' ability to build and maintain a well-oiled reimbursement machine.

What is your Reimbursement department "elevator pitch" to Health System department leaders? What do you wish everyone understood better?

In general, the Reimbursement department's activities involve analyzing and aggregating information and data well after the close of the fiscal year. That means by the time we see the information the content and format is set. Very often, we need to prepare an off-line analysis to get the data to fit our needs and this off-line analysis can be time consuming and less than ideal. It would be very helpful to have input on the front end when the operating departments are making design and procedure decisions.

In addition, operational changes during the year should be communicated and discussed with the Reimbursement department as these may impact how expenses are grouped or how statistics are accumulated and reported on the various cost reports and surveys we file, all of which have a bottom line impact to the organization.

The efforts of the Reimbursement department drives funding in potentially unexpected areas such as medical education, transplants, provider-based clinics, 340B programs, traditional IPPS settlements, DSH and bad debts. Capturing and retaining funding for these services and programs requires very detailed reporting in highly regulated areas. Failure to adequately plan and communicate across the health system leaves the organization open to audit risks or lost reimbursement.

What are the key departments for reimbursement managers to include in a planning and communication strategy?

Finance and Accounting sits at the top of this list for obvious reasons. The general ledger is the foundation for most regulatory and reimbursement reports. Other departments that fall under the Finance umbrella such as Payroll, Billing and Patient Financial Services, Budgeting and Accounts Payable are also very important sources of information. Communication with these departments is critical to our reporting.

At the same time, some of the departments you may not think about that also have an impact on reimbursement are Facilities Management, Corporate Compliance, clinical departments involved in bed management, the residency program and clinic and physician practices, to name a few.

What are some best practices that have worked well for you?

Everyone is busy so it might seem hard to find the time, but we have found the professional and personal connections we have developed with peers in other departments has been very valuable and rewarding. Get to know your colleagues in other departments, ask them about what they do, what is most challenging and how you might be able to help. Over time, you can educate each other and more easily identify opportunities to communicate and work together to help one another out. In addition, we have found that setting up quarterly check-ins with each of the external departments has helped us plan and prepare for "busy season" and also keeps us aligned and

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Unlocking Financial and Operational Benefits: Energy Audits and Efficiency Improvements for Healthcare Facilities

Emma Raymont

By: Emma Raymont, PE, CEM

In today's rapidly evolving healthcare landscape, financial efficiency and sustainability are becoming critical components of operational success. While healthcare organizations primarily focus on patient care, there is a significant opportunity in addressing another area that can yield substantial benefits: energy efficiency. Conducting an energy audit and implementing comprehensive energy efficiency improvements can lead to:

- Real cost savings,
- Increased operational performance,
- Enhanced indoor comfort, safety and health
- Environmental, Social and Governance (ESG) reporting benefits.

There are significant financial advantages that may be realized through energy efficiency upgrades and even more importantly there are incentives available to healthcare facilities in New Jersey to make implementing these improvements seamless and cost-effective.

The Importance of Energy Audits

An energy audit is a detailed examination of a facility's energy use, identifying opportunities for cost savings and efficiency improvements. For healthcare facilities, where energy consumption is high due to the need for 24/7 operation and specialized equipment, an energy audit can uncover significant inefficiencies and reveal practical solutions.

Key Components of an Energy Audit:

- **Energy Consumption Analysis:** Understanding how and where energy is used.
- **Benchmarking:** Comparing facility performance against similar institutions.
- **Identification of Inefficiencies:** Highlighting outdated equipment or practices.
- **Actionable Recommendations:** Providing a roadmap for improvements.
- **Financial Impact Assessment:** Estimating cost savings, incentive levels and return on investment (ROI).

Financial Benefits of Energy Efficiency Improvements include:

1. **Reduced Operating Costs:** One of the most immediate benefits is the reduction in energy bills. Upgrading HVAC systems, lighting, insulation and air sealing can dramatically lower energy consumption.
2. **Increased Asset Value:** Energy-efficient buildings often have higher market values due to lower operating costs and improved building performance.
3. **Enhanced Budget Allocation:** Savings from energy costs can be redirected towards patient care, staffing, and other critical areas.
4. **Attractive ROI:** Many energy efficiency projects offer quick payback periods, with substantial long-term savings.
5. **Operational Resilience:** Energy-efficient systems are often more reliable and require less maintenance, reducing downtime and repair costs.

Financial Incentives and Resources in New Jersey

There are various programs, tax deductions and incentives in place to support New Jersey healthcare facilities in their energy efficiency endeavors. These financial resources can substantially offset the costs of audits and improvements, making the financial benefits even more compelling.

Take the Federal 179D Tax Deduction, for example, expanded under the Inflation Reduction Act (IRA) which can be leveraged by healthcare facilities. 179D enables building owners to claim a tax deduction (up to $5.00 per square foot) for installing energy-efficient systems. Qualifying upgrades include interior lighting, building envelope and HVAC or hot

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communicating.

A reimbursement representative should be involved in budgeting, planning, and organizational change conversations. This integration ensures departments such as Finance, Payroll, IT and Data Analytics, Billing and Accounts Payable understand the intricacies of cost reporting and reimbursement, aligning their reporting processes accordingly. We would also recommend getting involved in different committees throughout the organization. We find the better our relationship is with different departments the more they involve us in their decision-making processes.

Above all, we find senior leadership support is critical to long term success. It is important to identify where senior leadership support of the reimbursement department might need improvement. By fostering communication, sharing data and collaborating effectively, hospital departments can collectively contribute to accurate cost reporting, efficient processes and maximized reimbursement under Medicare guidelines.

About the authors

Christine Gordon is Director of Reimbursement at Virtua Health System. She can be reached at cgordon@virtua.org.

Angela Kaminsky is Senior Manager at Forvis Mazars. She can be reached at angela.kaminsky@us.forvismazars.com.

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water systems. These upgrades must reduce energy costs by 25% or more compared to the building's existing usage.

Healthcare facilities can also take full advantage of available incentives and financial support to reduce initial project costs. For eligible customers of New Jersey's utilities including PSE&G, New Jersey Natural Gas, Atlantic City Electric, Jersey Central Power & Light, South Jersey Gas or Elizabethtown Gas customers in NJ, the Engineered Solutions Program is available with financial incentives that can cover 30%-70% of project costs with interest-free, on-bill financing offered on the balance over five years. Comprehensive energy retrofits can offset project costs for improvements to reduce energy usage, providing owners the financial flexibility to implement whole-building improvements for the comfort, health and safety of residents, staff, and visitors. Complimentary energy audits are available to healthcare facilities to provide them with a better understanding of their energy use and improvement areas to gain increased energy and cost savings.

For healthcare facilities not yet ready to undertake holistic energy efficiency upgrades, New Jersey's utility companies provide a variety of incentives for prescriptive and custom measures. These incentives are ideal for retrofits to HVAC systems, LED lighting and more, which can still lead to significant energy savings and cost reductions. The rebate amounts are typically predetermined and can cover a significant portion of the upgrade cost, making it easier for healthcare facilities to transition to more energy-efficient options without a hefty upfront investment.

By leveraging tax reductions and financial incentives, healthcare facilities can make energy efficiency improvements that provide immediate benefits and lasting energy and cost savings.

Conclusion

For healthcare facilities in New Jersey, conducting an energy audit and implementing comprehensive energy efficiency improvements offer a dual benefit:

- reducing energy consumption and operational costs and
- contributing to more sustainable, comfortable and healthy operation.

By adopting a strategic approach and taking advantage of available financial resources, healthcare institutions can achieve substantial cost savings, improve operational efficiency, and reinvest in patient care and other critical areas.

By focusing on these comprehensive energy efficiency strategies and the specific financial incentives available, healthcare facilities can turn energy management from a cost center into a source of significant savings and operational resilience.

About the Author

Emma Raymont, PE, CEM is a licensed Professional Engineer and an accomplished designer and trainer in HVAC and building science principles. Emma is the Director of Engineering at MaGrann Associates and has been responsible for the technical management of an engineering team supporting NJ utility energy efficiency programs for over 15 years, including oversight, quality, standards and customer satisfaction, as well as providing program direction during the construction phase of projects, working closely with contractors, equipment vendors and property staff.

Emma has dual degrees in Civil and Architectural Engineering from Drexel University, Philadelphia and a BA from McGill University, Montreal. She can be reached at emmaraymont@magrann.com.

Artificial Intelligence in Healthcare: Key Considerations

Gerry Blass

By: Gerry Blass

Artificial intelligence (AI) has rapidly evolved as a transformative force in healthcare. From improving diagnostics to optimizing treatment plans, AI offers significant opportunities to enhance patient outcomes. However, integrating AI into healthcare raises concerns around privacy, data security, and regulatory compliance, especially with laws like HIPAA. This article explores the diverse use cases of AI in healthcare, the governance frameworks guiding its use, and the critical importance of privacy and security in this evolving landscape.

AI Use Cases in Healthcare

AI is revolutionizing various aspects of healthcare, enabling smarter, faster, and more personalized care. Here are some use cases:

Administrative Efficiency

AI streams administrative processes such as billing, appointment scheduling, and claims management. This reduces the burden on healthcare staff, minimizes errors, and enhances operational efficiency.

Personalized Treatment Plans

AI can assist in crafting personalized treatment plans by analyzing individual patient data, including genetics, lifestyle, and medical history.

With AI-powered precision medicine, healthcare providers can offer tailored therapies that improve patient outcomes with complex or rare conditions.

Diagnostics and Imaging

AI-driven diagnostic tools can accurately analyze medical images such as X-rays, MRIs, and CT scans. For example, AI algorithms detect early signs of diseases like cancer, diabetic retinopathy, and heart conditions, often outperforming human radiologists in speed and precision. The ability to identify subtle patterns that the human eye might miss makes AI a game-changer in diagnostics.

Predictive Analytics

AI can analyze vast amounts of patient data to predict potential health outcomes. By identifying at-risk populations, predicting disease progression, and forecasting hospital readmission rates, AI can help healthcare providers implement preventive measures and allocate resources more efficiently. This capability is particularly valuable in managing chronic conditions and improving population health.

Governance in Healthcare with AI:

As AI becomes more embedded in healthcare, governance frameworks must evolve to ensure responsible and ethical use. Key considerations include:

Regulatory Compliance

Regulatory bodies, such as the U.S. Food and Drug Administration (FDA), have begun establishing guidelines for AI in healthcare, particularly around medical devices and diagnostic tools. These guidelines ensure that AI technologies are safe, effective, and meet rigorous standards before deployment in clinical settings.

Collaboration and Stakeholder Engagement

Governance fosters collaboration between AI developers, healthcare providers, policymakers, and patients. Engaging stakeholders ensures that AI technologies align with clinical needs, patient safety, and ethical standards.

Ethical Use and Bias Mitigation

AI systems must be developed and deployed, focusing on fairness, transparency, and accountability. One of the most critical concerns is algorithmic bias, where AI models may inadvertently reinforce existing healthcare disparities due to biased training data. Governance structures must ensure that AI tools are continuously audited for fairness and that diverse datasets are used to minimize bias.

HIPAA and AI Integration

HIPAA mandates strict protections for patients' health information, regulating how healthcare providers, insurers, and related entities handle data. When integrating AI into healthcare, organizations must ensure that AI systems comply with HIPAA's Privacy and Security rules. These rules require appropriate administrative, physical, and technical safeguards to ensure the confidentiality, integrity, and availability of protected health information (PHI).

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Five Tips for Implementing Practical Data Governance

George Dealy

By: George Dealy

Data governance may seem like an abstract idea, but it becomes quite clear what it is and why it's important when you find that you need it, and don't have it. One of the challenges is that data governance covers a broad scope of concepts and practices, including:

- Data Quality Management
- Metadata Management
- Data Security and Privacy
- Data Stewardship
- Technology and Tools

Tackling all of those at once seems daunting and impractical in most cases. However, the goal of data governance is to both ensure and maximize the value of your data assets. There are a few things you can do to make a big difference without substantial up front investments in time, effort, or dollars. In this article we'll focus on harnessing the value of existing information assets for decision support, specifically in the healthcare industry. We'll refer to "decision support" as a generic term that covers everything from business intelligence and analytics to AI and machine learning. Essentially, anything that supports better decisions.

Transactional systems, such as electronic health records and enterprise resource planning, are an organization's lifeblood. Without them enterprises wouldn't be able to function. Beyond that, the information contained in these systems can be leveraged for data-driven decision making to increase productivity and efficiency and create competitive advantage. However, the primary purpose of these systems is not to provide effective decision support, and the most useful information requires combining data from multiple systems. That's where data governance comes in: providing the structure and processes to identify opportunities and create value through creative secondary use of data assets.

The data stewardship and metadata management aspects of data governance are particularly helpful in locating the best opportunities and determining which ones to pursue. Beyond that, data governance helps organizations decide how the most valuable information should be defined, curated, and delivered. At Dimensional Insight we've worked with clients in healthcare and other industries to create both custom decision support systems as well as off-the-shelf solutions by leveraging our analytics tools and applications. Through experience gained over decades we've come to appreciate the importance of data stewardship and the essential role that metadata management plays in it. In healthcare specifically, the number of quantitative measures (KPIs) tends to be quite large and the complexity often boarders on overwhelming. To help deal with this, we've devised an approach for building a foundation for effective decision support governance that's practical to implement and produces results quickly. We'll share with you here five best practice tips at the core of that approach. Though we've incorporated these into our own products, they are not technology-specific and can be implemented with the most basic tools, such as spreadsheets.

Best Practice #1: Identify and engage stakeholders— early and often!

Many data governance initiatives ultimately fail due to indifference or lack of support from the stakeholders who stand to benefit most. With their enthusiastic commitment, however, the likelihood of success increases dramatically. Start your search for key stakeholders with business/service line "owners" who have well defined and quantifiable accountability. Among them you'll want to seek out managers with an analytical orientation and thirst for data. They will appreciate high value, trustworthy information and can leverage it to make better decisions. And as they do, they will become your champions, espousing the benefits of "good data." Other managers may realize the benefits of reliable decision support and actionable data and will become engaged to keep up with their champion counterparts.

Best Practice #2: Start with the KPIs and work back toward the data.

Key performance indicators (KPIs) are the metrics that help distill vast volumes of information into something meaningful and provide a basis for objectively measuring performance. The historical tendency when building decision support systems is

to start with the data and work forward. Inevitably, the lack of engagement with the ultimate consumers of the information results in low adoption and eventual abandonment of the system. By instead focusing on stakeholder needs upfront in a very deliberate and quantitative way, you'll be able to home in more precisely on what's important. Engaging stakeholders early ensures their commitment since they drive the process of defining their own requirements. Just coming up with a preliminary list of the KPIs that are most valuable to stakeholders is a great start to the process. There will be plenty of opportunity for consensus building and conflict resolution along the way, but KPIs will provide a precise foundation for generating discussion.

Best Practice #3: Determine what sources of data are available, viable, and trustworthy.

You may find that some of the KPIs stakeholders request may be impractical because the available data doesn't meet the criteria of the KPI. It may not be complete, reliable, refreshed at a frequency that would make the information useful, etc. Ruling out both the KPIs and data that aren't practical to include early will save you time, effort, and heartache in the long run. For the data that does represent good candidates to use with KPIs, you'll need to get very specific. What systems will the data come from? What are the required datasets and data element definitions? Does the data conform to standards where necessary? How will the data get extracted, transferred and transformed? You won't necessarily be able to answer all these questions right away, but those answers —or lack thereof — will help you to prune the list of candidate KPIs to those that are both possible and valuable enough to implement and maintain. This is where spreadsheets, or really any tool capable of managing lists, are invaluable. An inventory of potential data assets will give you a head start in managing metadata. This can start at a very general level, like a list of datasets, and incrementally get more specific, like data elements and formats, as needs dictate.

Best Practice #4: Set up a system for managing KPI metadata.

When we began building packaged off-the-shelf analytical solutions for healthcare over ten years ago, we quickly confirmed that the KPI-driven approach was the way to go. We use a simple tool, which we call a "Measure Master," to document all aspects of a KPI, starting with a narrative description that stakeholders, information consumers and data managers can agree on as a starting point. That's what metadata is. It complements the actual data (a KPI for example) with information that describes it. The value, and success, of the KPI will rely on the precision of the metadata in everything from the source of the data to the data elements selected to the logic applied to that data.

You'll invariably find that you may not be able to reach consensus on some things. That's because you may be talking about more than one KPI for the same concept with legitimately different requirements across stakeholder groups. Documenting and communicating these differences will help resolve conflicts and ensure the best possible results. Using a tracking system will help keep the process organized and ensure critical decisions are captured. You may well be able to use a system your organization already has (like a CRM or issue management application) or any number of generic commercial or open-source tools. It doesn't need to be fancy. Something that tracks ownership and accountability of KPIs and documents the discourse around how they evolve will be sufficient and practical to implement. It will also be critical to maintaining KPIs over time as requirements, data, and stakeholders change. Finally, if possible, the metadata should be integrated directly with the data it describes. This way information consumers will be able to interrogate the decision support system to help identify which KPIs are most useful and explore what they represent.

Best Practice #5: Validate! Validate! Validate!

We'll skip the part about implementing the systems that embody what's been defined. Suffice it to say that it is an important step and can be done with a variety of tools and technologies. But what's critically important and independent of any implementation technology is to make sure that the resulting KPIs reliably match the definitions agreed to and documented through the metadata. In our projects we've found that investing effort in extensive validation ensures successful use of the system and ultimately strong adoption. The work that goes into the preceding steps will pay off during validation in several ways:

- Stakeholder ownership and accountability for KPIs will provide the definitive word on what's "valid."
- The KPIs will serve as a framework for what gets validated. An individual KPI will just be the starting point for everything that needs to be validated, but if the KPI value isn't what is expected, you'll know quickly that there's an issue somewhere in the definition, data and/or logic.
- Validation will be the ultimate test of just how suitable and reliable the data source for a KPI is. Hopefully you will have avoided surprises through due diligence early on, but they still may happen, so you'll need to be ready to pivot.
- Your metadata management system and processes will prove invaluable during validation as they will help answer questions and resolve differences that arise. Validation will also sometimes expose the need to revise a KPI. The system will help to keep track of those changes and the process necessary to implement and re-validate them.

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Wednesday - October 9th

Checking In	**9:00a**		**Seminole Ballroom**
Lunch	**11:30a - 12:30p**		**Seminole Ballroom**
General Session #1	**12:00p - 1:00p**	**(1 CPE)**	**Seminole Ballroom**
Summary of the Federal Fiscal Year (FFY) 2025 Centers for Medicare & Medicaid Services' (CMS) Final Rulings and Hot Reimbursement Topics			
Thomas Morse & Tracey Roland, TPR Solutions LLC			
Networking Break	**1:00p - 1:30p**		**Seminole Ballroom**
Breakout #1	**1:30p - 2:20p**	**(1 CPE)**	
Strategies to unlocking potential and improving productivity			**Brighton Ballroom 1**
Kaylar Winn, Geisinger Health & Amanda Houssein, Geisinger Health			
Declining Self-Pay Recovery Rates -- Want to know why?			**Brighton Ballroom 2**
Steven Kusic, NRAGroup.com			
2024 Legislative Update: Implications for Healthcare RCM Leaders			**Brighton Ballroom 3**
Joel Hubbart, FinThrive & Nicole Clawson, Pennsylvania Mountains Healthcare Alliance (PMHA)			
Transtion between Breakouts	**2:20p to 2:30p**		
Breakout #2	**2:30p to 3:20p**	**(1 CPE)**	
Tax Update			**Brighton Ballroom 1**
John Smith, WithumSmith+Brown, PC			
Understanding Observation Services in 2024			**Brighton Ballroom 2**
Ronald Hirsch, R1			
Medicare Enrollment Updates, Challenges, and Potential Penalties for Non Compliance			**Brighton Ballroom 3**
Alicia Shickle, ProCode Compliance Solutions, LLC			
Networking Break and Snack	**3:20p to 3:50p**		**Seminole Ballroom**
Breakout #3	**3:50p to 4:40p**	**(1 CPE)**	
A Well-Oiled Machine: Departments Working Together for Better Reimbursement			**Brighton Ballroom 1**
Angela Kaminsky, FORVIS & Christine Gordan, Virtua			
Discovering new Health System revenue using bots to assist with patient benefit enrollment			**Brighton Ballroom 2**
Pedram Afshar, Sage Health & Garrick Stoldt, Saint Peter's University Hospital			
The New Data Privacy Laws, Update on Privacy Class Action Litigation, and Mitigating Privacy Risk Through Insurance			**Brighton Ballroom 3**
Steven Weisman & Scott Christie, McCarter & English, LLP			
Break	**4:40p to 5:30p**		
Charity Event	**5:30p - 7:30p**		
Charity - Breakthrough T1D, formerly known as the Juvenile Diabetes Research Foundation			**Seminole Ballroom**
Day Complete	**7:30p**		

Thursday - October 10th

Buffet Breakfast	**8:00a - 8:45a**		**Seminole Ballroom**
Chapter Awards	**8:45a to 9:00a**		**Seminole Ballroom**
General Session #2	**9:00a - 9:50a**	**(1 CPE)**	
Navigating the Nexus: Understanding A.I. Opportunities and Cybersecurity Threats in Healthcare			**Seminole Ballroom**
Gerry Blass, ComplyAssistant			
General Session #3	**9:50a to 10:40a**	**(1 CPE)**	
Charting the Course: Building a Sustainable Health Care Workforce for the State of New Jersey			**Seminole Ballroom**
Roselyn Feinsod, Ernst & Young & Cathleen, Bennett, New Jersey Hospital Association			
Networking Break & Snack	**10:40a to 11:00a**		**Seminole Ballroom**
General Session #4 - Keynote	**11:00a - 12:00p**	**(1 CPE)**	
Never underestimate the power of a denial!			**Seminole Ballroom**
Claire Skelley & Jean Bryll, RWJBarnabas Health			
Buffet Lunch	**12:00p - 1:05p**		**Seminole Ballroom**
Breakout #4	**1:05p to 1:55p**	**(1 CPE)**	
GAAP Update			**Brighton Ballroom 1**
Michael George, Withum			
Managed Care Benchmarking in the Era of Price Transparency			**Brighton Ballroom 2**
Keith Needham & Kevin Coonan, Baker Tilly US, LLP			
Coding Compliance and Risk Mitigation: Protecting Your Revenue			**Brighton Ballroom 3**
Nancy Clark, Eisner Advisory Group			
Powering Value-Based Contract Success—Strategies to Empower Providers and Drive Operational Excellence			**Brighton Ballroom 4**
Dr. Raj Lakhanpal, SpectraMedix			
Transtion between Breakouts	**1:55p to 2:00p**		
Breakout #5	**2:00p to 2:50p**	**(1 CPE)**	
Monetizing Clean Energy Capital Improvements			**Brighton Ballroom 1**
Lynn MucenskiKeck, Withum			
Fight Payer Denials with Final Rule CMS-4201-F			**Brighton Ballroom 2**
Amber Owens, ARO Healthcare Consulting Group			
Is this the End of Agency Deference? The New Landscape of Administrative Law and the Impact on Healthcare Providers.			**Brighton Ballroom 3**

Thursday - October 10th

James Robertson & Paul Croce, Greenbaum, Rowe, Smith & Davis, LLP			
Lessons learned from a successful AI Implementation of Computer Assisted Coding			**Brighton Ballroom 4**
Beth Kushner, St. Joseph Health System			
Networking and Ice Cream Break	**2:50p to 3:10p**		**Seminole Ballroom**
Breakout #6	**3:10p to 4:00p**	**(1 CPE)**	
Utilizing Educational Relationships to Address Workforce Challenges			**Brighton Ballroom 1**
Craig Nesta, Emerson Health			
Automating Data Governance to Support Effective Analytics			**Brighton Ballroom 2**
George Dealy & Amato Amarain, Dimensional Insight			
Navigating Compliance: Lessons from Recent Enforcement Activity			**Brighton Ballroom 3**
Leslie Boles, Revu Healthcare, LLC			
From Denial to Recovery: Upgrading Your Approach to DRG Downgrades			**Brighton Ballroom 4**
Annabelle Seippel, CorroHealth			
Transtion between Breakouts	**4;00p to 4:10p**		
General Session #5	**4:10p to 5:00p**	**(1 CPE)**	
Revenue Cycle Round Table			**Seminole Ballroom**
Moderated by: Dennis Jones, Jefferson Health			
Jean Bryll, RWJ Barnabas Health			
Lynda Carbone, Inspira Health			
Leah Klinke, Hackensack Meridian Health			
Vanessa Mackay, WMC Health			
President's Reception	**6:00p to 8:00p**		**Plum Lounge**
Late Night Event	**10:00p to 1:00a**		**The Balcony**

Friday - October 11th

Buffet Breakfast	**8:00a - 9:00a**		**Seminole Ballroom**
General Session #6	**9:00a to 9:50a**	**(1 CPE)**	
50 Years of Hospital Rate-Setting in New Jersey – a Panel			**Seminole Ballroom**
John Dalton, Moderator, Healing American Healthcare Coalition			
Panelists: Gene Arnone, Mike Kalison, George Popko, & Jo Suprin			
General Session #7	**9:50a to 10:40a**	**(1 CPE)**	
Government Policy & Reimbursement Panel			**Seminole Ballroom**
Moderated by Chris Czvornyek, Hospital Alliance of New Jersey			
Cort Adelman, Virtua Health			
Kenneth Morris, Jr., MHA, MA, St. Joseph's Health			
Christine Stearns, NJHA			
Break	**10:40a to 10:50a**		**Seminole Ballroom**
General Session #8	**10:50a to 12:05p**	**(1.5 CPE)**	
"C" Suite Panel			**Seminole Ballroom**
Gui Valladares, Chief Financial Officer, Penn Medicine Princeton Health			
Leigh Ehrlich, Executive Vice President and Chief Financial Officer, Main Line Health			
Event Complete	**12:05p**		

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Security Risks

AI systems are not immune to cybersecurity threats. The complexity of AI models can make them vulnerable to attacks such as data breaches, model manipulation, and adversarial inputs. Healthcare organizations must implement robust security measures, including encryption, access controls, and continuous monitoring, to protect AI systems and patient data from malicious actors.

Privacy, Security, and HIPAA Compliance

One of the most critical aspects of AI in healthcare is safeguarding patient privacy and ensuring data security, particularly in light of stringent regulations like HIPAA.

Data Privacy Concerns

AI systems require vast amounts of data to function effectively, often drawing from electronic health records (EHRs), medical imaging, and genomic data. However, this raises significant concerns about patient privacy. AI systems may expose sensitive information without proper safeguards, leading to privacy violations and potential misuse.

De-identification of Data

One way to mitigate privacy risks is to use de-identified data for AI training and analysis. HIPAA provides guidelines on properly de-identifying health information, ensuring that individuals cannot be easily re-identified from the data. By using de-identified datasets, healthcare organizations can benefit from AI advancements while minimizing privacy risks.

The Future of AI in Healthcare

As AI continues to reshape the healthcare landscape, its potential for improving patient outcomes, enhancing operational efficiency, and reducing costs is undeniable. However, to fully realize these benefits, addressing the challenges of governance, privacy, security, and compliance is essential.

Summary

AI's role in healthcare is poised to expand, but its success will depend on how well healthcare organizations navigate the delicate balance between innovation and compliance. With proper governance and a focus on privacy and security, AI can become a powerful tool for improving healthcare outcomes for all.

About the author

Gerry is President and CEO of ComplyAssistant, which provides GRC software and healthcare cybersecurity service solutions to over 100 healthcare organizations of all sizes, focusing on HIPAA-HITECH-OMNIBUS, HICP (Health Industry Cybersecurity Practices), PCI, NIST, and other federal and state healthcare regulations.

Gerry currently co-chairs the NJ HIMSS Privacy, Security, and Compliance Committee and participates in national and local chapter events that include NY, NJ, and Delaware Valley.

Gerry regularly writes for healthcare compliance and health IT publications. He's an active member, contributor, and speaker at industry association events with HIMSS, HFMA, NJPCA, NJAMHAA, and HCCA. He can be reached at gerry@complyassistant.com.

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We hope these five tips have given you a practical roadmap for implementing data governance at your organization. And here's one additional bonus tip: Listen and respond to your information consumer community. The success of the systems implemented from the work you do on data governance will rise and fall with adoption. And the only way a decision support system will be adopted is if it provides trustworthy, reliable information that will conveniently support data-driven decision making. These systems tend to be "optional" in their use, so if they don't provide tangible value, they won't get used. Information consumers will be the finger on the pulse of how useful systems are, largely through their feedback. Hopefully it will be positive, but critical feedback is even more important. If you respond to it quickly and effectively, you'll gain the trust and support of the user community.

Reference:

"Data governance: A conceptual framework, structured review, and research agenda", International Journal of Information Management, Rene Abraham , Johannes Schneider, Jan vom Brocke, Institute of Information Systems, University of Liechtenstein, Fürst-Franz-Josef-Strasse, 9490 Vaduz, Liechtenstein, August 2019

About the author

George Dealy is Vice President of Healthcare Applications at Dimensional Insight, Inc. George sets the direction for Dimensional Insight's healthcare solutions product line and leads the product development team. He is passionate about the possibilities for applying analytics technology to healthcare in ways that will improve the well-being of providers, patients and entire populations. George's 25+ years of experience in information technology, including senior roles in business development, product management and professional services, give him a unique perspective on the challenges of assimilating new technologies into organizations and industries. He can be reached at gdealy@dimins.com.

Maintaining Compliance Through Price Transparency: The Single-Vendor Platform Advantage

Mark Janiszewski

By: Mark Janiszewski

In today's digital era, along with continued pressure on operating margins, healthcare providers are increasingly turning to technology to streamline processes and improve the patient experience. New regulations provide the opportunity to further level technology to meet these new regulatory demands and provide the opportunity to improve the patient experience.

The Hospital Price Transparency Rule and No Surprises Act have dramatically changed what providers are expected to make available to patients seeking care. These regulations, while distinct in their requirements, both aim to ensure hospitals publicly disclose their charges in a transparent and accessible manner, empowering patients with vital information about medical costs.

Despite these rules being in place for several years, compliance remains a significant challenge for many hospitals, and the rules have been updated with additional requirements. The Patient Rights Advocate's Fifth Semi-Annual Hospital Price Transparency Compliance Report reveals that in 2023 only 36% (721) of the 2,000 hospitals analyzed fully met the Price Transparency Rule's requirements. This underscores the ongoing struggle within the healthcare industry to achieve full compliance and highlights the critical need for continued efforts towards transparency.

Determining healthcare pricing has always been tricky, especially trying to improve the financial experience for patients while sticking to strict price transparency rules. Patients today want to feel confident their care choices fit within their budgets. When they trust their billing estimates are accurate, they're much more likely to pay upfront, making the financial process smoother and easier for everyone involved.

The Power of a Single-Vendor Platform

A comprehensive, single-vendor platform that provides payment estimations can be a game-changer. It significantly addresses both hospital and physician compliance issues with price transparency, ultimately fostering a more transparent and patient-friendly healthcare environment.

Top Considerations in a Vendor

When evaluating vendors for payment estimation tools, it's crucial to look for features that help ensure both compliance and transparency. Here are key elements to consider:

- **Compliant Good Faith Estimates:** The tool should generate a compliant Good Faith Estimate that includes detailed, itemized services and expected costs from providers. This helps patients understand exactly what they are paying for with transparency in billing.
- **Co-Provider and Co-Facility Information:** It's important the payment estimator displays comprehensive co-provider and co-facility information on the self-pay or uninsured Good Faith Estimate. This feature gives patients a complete view of all potential costs involved in their care.
- **Notice of Consent for Out-of-Network Services:** A robust payment estimator tool should provide a Notice of Consent, allowing out-of-network professionals who provide services at an in-network facility to balance bill for certain items or services. This keeps patients informed and helps them make consent-based decisions regarding their care.

Choosing a vendor with these capabilities will enhance the patient's financial experience, help ensure compliance with regulations and provide the transparency needed for informed healthcare decisions.

About the Author

Mark Janiszewski is responsible for product leadership at FinThrive focused on the patient experience and denial prevention. With extensive product management experience, Janiszewski joined FinThrive in 2018 and works closely with customers as well as development, marketing, sales, and operations to strengthen FinThrive's solutions and deliver best-in-class offerings. He embraces the challenge and opportunity to reduce the waste in the healthcare system so that more healthcare dollars can be focused on keeping patients healthy. Mark can be reached at mark.janiszewski@finthrive.com.

The Clean-Energy Direct-Pay Election for Not-For-Profits and Governmental Entities

Lynn Mucenski-Keck, CPA

By: Lynn Mucenski-Keck, CPA

As part of the Inflation Reduction Act of 2022, P.L. 117-169, passed in August 2022, hundreds of billions of dollars in governmental funding and costs were allocated to energy and climate initiatives. For the first time, tax-exempt organizations, including not-for-profits and governmental agencies, can claim certain energy credits on their federal income tax returns and receive a refund from the federal government even if they have zero federal income tax liability. This ability is due to new Sec. 6417, Elective Payment of Applicable Credits ("direct pay").

While many in the accounting profession and clean-energy industry have highlighted the direct-pay election under Sec. 6417, a lack of understanding — and fast-approaching deadlines — may cause applicable entities to leave significant cash outlays with the federal government instead of receiving them for their operations.

For tax years beginning after Dec. 31, 2022, the direct-pay election generally must be made by the tax return due date, including extensions of time to file. Proposed regulations clarify that direct pay cannot be made on an amended return. The proposed regulations also do not provide late-filing regulatory relief under Regs. Secs. 301.9100-1 through -3 for direct-pay elections that are not filed timely (Prop. Regs. Sec. 1.6417-2(b)(1)).

For example, if applicable entities were involved in clean-energy initiatives in the 2023 tax year, and the Sec. 6417 direct-pay election is not made on a timely filed 2023 federal income tax return, the clean-energy refundable credit for that year will no longer be available. Under the proposed regulations, there currently appears to be no mechanism for applicable entities to request a refund later.

Some commonly asked questions surrounding the Sec. 6417 direct-pay election are addressed below.

What entities are eligible to make a Sec. 6417 direct-pay election?

- Applicable entities that can make a Sec. 6417 direct-pay election include (Sec. 6417(d)(1)):

  Any organization exempt from tax under Sec. 501(a);
- Governments of U.S. territories and political subdivisions thereof;
- States, the District of Columbia, and political subdivisions thereof;
- Agencies and instrumentalities of a state, the District of Columbia, Indian tribal governments, a U.S. territory, or a political subdivision thereof;
- The Tennessee Valley Authority;
- Indian tribal governments and political subdivisions thereof;
- Alaska Native Corporations; and
- Rural electric cooperatives.

What types of production and investment activities would the applicable entity need to be involved in to apply for the Sec. 6417 direct-pay election?

Applicable entities can make the direct-pay election in association with the following credits for investment in clean-energy projects and the production of clean energy (Sec. 6417(b)):

IRC section	Description
Sec. 30C	Alternative fuel vehicle refueling property
Sec. 45	Renewable electricity production credit
Sec. 45Q	Carbon oxide sequestration credit
Sec. 45U	Zero-emission nuclear power production credit
Sec. 45V	Clean hydrogen production credit
Sec. 45W	Qualified commercial clean vehicle credit (limited to certain tax-exempt entities)
Sec. 45X	Advanced manufacturing production credit
Sec. 45Y	Clean electricity production credit
Sec. 45Z	Clean fuel production credit
Sec. 48	Energy credit
Sec. 48C	Advanced energy project credit
Sec. 48E	Clean electricity investment credit

Common investment energy projects by applicable entities include geothermal, energy-storage technology, active solar energy, microgrids, combined heat and power systems, commercial electric vehicles, and electric charging stations. Common clean-energy production projects undertaken by applicable entities include community geothermal wells, wind farms, solar arrays, and energy-storage technology.

Under Sec. 48, applicable entities could receive a federal energy credit as high as 50%, depending on whether certain requirements are met, including if the energy project is located in an energy community, meets the domestic-content requirement, has a maximum net output of less than 1 megawatt, or meets the prevailing wage and apprenticeship requirements. For solar energy and wind projects, applicable entities could receive an additional 10% to 20% if they are located in qualified low-income areas.

Under Sec. 45W, commercial clean vehicles provide a maximum federal income tax credit of $7,500, or $40,000 if the gross vehicle weight is 14,000 pounds or greater (Sec. 45W(b)(4)).

Under the Sec. 30C credit for alternative fuel vehicle refueling property, the maximum credit for a charging station that is depreciable property is 30% of the costs if the prevailing wage and apprenticeship requirements are met, not to exceed $100,000 per station (Secs. 30C(a), (b), and (g)).

Example: Assume a calendar-year-end not-for-profit entity placed in service a large commercial solar panel that would generate 250 kilowatts of electricity in the 2023 tax year. The cost is estimated to be $750,000. Provided that the total expenses are deemed eligible costs for the Sec. 48 energy credit and the total maximum net output is less than 1 megawatt, the not-for-profit could generate a federal tax credit (refund) of $225,000, or 30% of the cost. The applicable rate is 30% because the project was not located in an energy community and did not meet the domestic-content requirement.

The timing of when the credit can be claimed is generally based on the tax year in which the project was placed in service. Therefore, applicable entities should closely review clean-energy projects placed in service in the 2023 tax year before filing their 2023 federal income tax returns.

If the applicable entity receives other federal or state funding or grants for the energy project, do they reduce the amount that can be claimed with a Sec. 6417 direct-pay election?

Tax-exempt income, including income from certain grants and forgivable loans, used to purchase, construct, reconstruct, or otherwise acquire investment-related credit property, is included in the property's basis when determining the applicable credit. Investment-related credit property is defined as alternative fuel vehicle refueling property (Sec. 30C), qualified commercial clean vehicle property (Sec. 45W), energy property (Sec. 48), an advanced energy project (Sec. 48C), and clean electricity investment property (Sec. 48E) (Prop. Regs. Sec. 1.6417-2(c)(3)).

One potential limitation to an investment credit with respect to tax-exempt income used to fund the energy project is that the total grant, forgivable loan, or other income exempt from taxation plus the federal income tax credit determined cannot exceed the total costs of the investment-related credit property. If the combination of tax-exempt funding and the applicable federal credit exceeds the project's total costs, then the applicable federal credit amount is reduced (id.).

Example: School District A receives a tax-exempt grant for $300,000 from the U.S. Environmental Protection Agency to purchase an electric school bus. A purchased the electric school bus for $400,000, consisting of the grant and $100,000 of A's unrestricted funds. A's basis in the school bus is $400,000, and A's commercial clean vehicle credit is $40,000. Since the amount of the grant plus the commercial clean vehicle credit ($300,000 + $40,000) is less than the total cost of the electric school bus ($400,000), the commercial clean vehicle credit will not be reduced.

Certain credits can be reduced to the extent they are financed with tax-exempt debt. For example, the renewable electricity production and energy tax credits can be reduced by up to 15% if the project is financed with tax-exempt debt (Secs. 45(b)(3) and 48(a)(4)).

How do applicable entities make a Sec. 6417 direct-pay election?

A direct-pay election must be made on an annual income tax return, which is defined as:

- For any taxpayer normally required to file an annual tax return with the IRS, such annual return;
- For any taxpayer that is not normally required to file an annual tax return with the IRS (such as taxpayers located in the U.S. territories), the return they would be required to file if they were located in the United States, or, if no such return is required (such as in the case of state, District of Columbia, local, or Indian tribal governmental entities), the Form 990-T, Exempt Organization Business Income Tax Return; and
- For short-tax-year filers, the short-year tax return (Prop. Regs. Sec. 1.6417-1(b)).

Again, the direct-pay election must be filed on an original return for the year the credit is being claimed and filed no later than the due date of the return, including extensions. For taxpayers in U.S. territories, the due date for making the election is the due date that would apply if the taxpayer were located in the United States. If a taxpayer is not required to file a federal income tax return, the due date for making the election is generally the 15th day of the fifth month after the applicable tax year end (Prop. Regs. Sec. 1.6417-2(b)(3)). Taxpayers that are not required to file income tax returns could request an automatic paperless six-month extension of time to file. Consideration should be given to applicable entities with fiscal year ends.

Are there any steps to be taken before filing the tax return in

which a Sec. 6417 direct-pay election is made?

Applicable entities must engage in the pre-filing registration process to make a Sec. 6417 direct-pay election on a federal income tax return. The IRS launched the pre-filing registration process to help decrease improper and fraudulent energy credit claims. Applicable entities must complete the pre-filing registration process electronically through the IRS electronic portal prior to filing their federal income tax return. By registering, an applicable entity will obtain a registration number that must be reported on the federal income tax return in the tax year the direct-pay election will be effective. The registration number must be renewed if the project is delayed and not placed in service until the following tax year (Temp. Regs. Sec. 1.6417-5T(c)). The IRS recommends registering the energy project at least 120 days before the due date, including extensions, of the federal income tax return that will report the clean-energy credit.

The following information will be required by the applicable entity when registering (Temp. Regs. Sec. 1.6417-5T(b)(5); see also IRS Publication 5884, ***Inflation Reduction Act (IRA) and CHIPS Act of 2022 (CHIPS) Pre-Filing Registration Tool***):

- The applicable entity's or electing taxpayer's general information, including its name, address, taxpayer identification number, and type of legal entity.
- Any additional information required by the IRS electronic portal, such as information regarding the taxpayer's exempt status under Sec. 501(a); that the applicable entity is a political subdivision of a state, the District of Columbia, an Indian tribal government, or a U.S territory; or that the applicable entity is an agency or instrumentality of a state, the District of Columbia, an Indian tribal government, or a U.S. territory.
- The applicable entity's tax year.
- The type of annual tax return(s) normally filed by the applicable entity or electing taxpayer, or that the applicable entity or electing taxpayer does not normally file an annual tax return with the IRS.
- The type of applicable credit(s) for which the applicable entity or electing taxpayer intends to make an elective payment election.
- For each applicable credit, each applicable credit property that the applicable entity or electing taxpayer intends to use to determine the credit for which the applicable entity or electing taxpayer intends to make an elective payment election.
- For each applicable credit property, any further information required by the IRS electronic portal, such as the:
  - Type of applicable credit property;
    Physical location (i.e., address and coordinates (longitude and latitude) of the applicable credit property);
  - Any supporting documentation relating to the construction or acquisition of the applicable credit property;
  - The beginning-of-construction date and the placed-in-service date of the applicable credit property;
  - If an investment-related credit property (as defined in Prop. Regs. Sec. 1.6417-2(c)(3)), the source of funds the taxpayer used to acquire the property; and
  - Any other information that the applicable entity or electing taxpayer believes will help the IRS evaluate the registration request.
- The contact person's name for the applicable entity or electing taxpayer. The contact person is the person whom the IRS may contact if there is an issue with the registration.
- A penalties-of-perjury statement, effective for all information submitted as a complete application, and signed by a person with personal knowledge of the relevant facts authorized to bind the registrant.
- Any other information the IRS deems necessary for purposes of preventing duplication, fraud, improper payments, or excessive payments under this section that is provided in guidance.

About the author

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

Protecting Revenue with Automation Technology for Medicaid and Charity Care Enrollment

Garrick Stoldt

Pedram Afshar

By: Garrick Stoldt & Pedram Afshar

PROBLEM

Saint Peter's University Hospital, located in New Brunswick, New Jersey, is a 478-bed major teaching hospital and is designated as a safety net hospital due to the high percentage of charity care it provides to the low-income population. In fact, the city where Saint Peter's is located has the 4th highest percentage of its population living below the Federal poverty guidelines among the 580 municipalities in New Jersey.

Saint Peter's needs to both maximize Medicaid reimbursement and remain in the top ten charity hospitals to take advantage of New Jersey's Charity Care subsidy, which is set at 96% of the Medicaid rate. Dropping out of the top ten positions would dramatically reduce this subsidy. Therefore, cost-effective and efficient enrollment in both programs is crucial to protect revenue.

To address this challenge, Saint Peter's employs a team of Resource Advisors and a vendor to assist patients in the application processes for both Medicaid and Charity Care.

The management concern is potential revenue leakage due to inefficiencies in the financial office, including:

Highly manual and reactive processes for Staff to identify eligible patients and collect their information for enrollment. In many cases, costly home visits are required.

Complex and time-consuming processes for patients, often requiring multiple trips to provide the necessary documentation, which results in many patients giving up.

Time-consuming quarterly Charity Care audit process that requires Staff to scramble to retrieve records.

Difficulty tracking productivity metrics for management, leading to many missed opportunities for patient enrollments.

These problems are exacerbated by the state's introduction of a new Medicaid outpatient transfer payment program. Starting in July 2024, the hospital will be paid $200.00 for every paid Medicaid outpatient encounter, regardless of the claim's value. The state is redirecting previous Charity Care subsidy dollars, which is matched by the Federal government on a 50/50 basis, to a program matched on a 2-for-1 basis by the Federal government. This change increases the need to qualify every patient encounter for Medicaid. The financial implications are huge for all hospitals that treat a substantial Medicaid-eligible population.

SOLUTION

Due to the importance of the problem, Saint Peter's decided to adopt a multi-faceted approach. In addition to internal staff and a supplementary vendor, Saint Peter's implemented a novel software to introduce automation technology into the benefit enrollment process. The software was designed to provide three key features:

First: It enabled human-supported "self-service" options for patients to:

- ***Proactively outreach to patients*** using algorithmic triggers, ensuring no patient was left uncontacted.
- ***Collect data from patients*** via their smartphones, enabling the creation of a greater number of complete and accurate applications.

Second: It empowered Staff with automation, enabling them to spend more time with patients who need extra help. The automation helped Staff to:

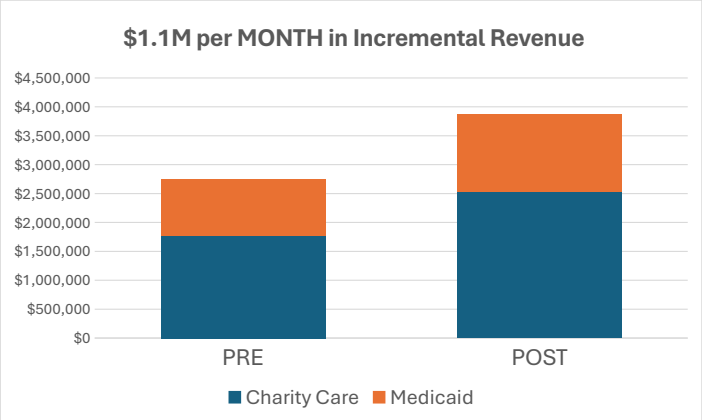
- ***Automatically integrate with portals*** such as New Jersey's MMIS.
- ***Automatically create and submit Medicaid applications*** using Robotic Process Automation (RPA) and bots.
- ***Digitally create and store Charity Care applications*** with digital indexing, dramatically reducing audit preparation time.

Third: It helped managers monitor real-time staff productivity

metrics and application statuses, ensuring nothing fell through the cracks. In summary, the project aimed to achieve better performance than what could be accomplished by either the in-house staff or the vendor alone.

Value proposition	In-house	Vendor	+ Technology
Knowledge of Eligibility Rules		Better	Best
Satisfying Patient Experience	Better		Best
Integrated and monitored process	Better		Best
Management overhead		Better	Best
Total revenue generated		Better	Best
Cost-to-Collect	Better		Best
Audit Process	Same	Same	Best

RESULTS



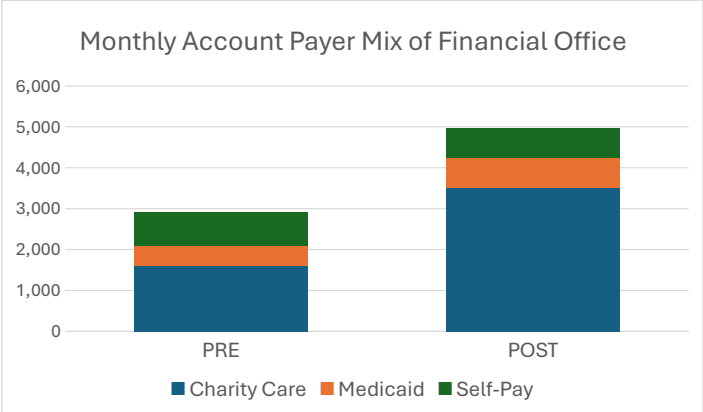
In total, monthly revenue increased by $1.1M per month. This was roughly divided into one-third Medicaid reimbursement and two-thirds Charity Care vouchers.

Revenue Breakdown per Month by Source			
	PRE	POST	*Incremental*
Staff - Medicaid	$984,000	$1,203,272	*$219,272*
Staff - Charity	$1,766,600	$2,471,244	*$704,644*
Medicaid Bot	$0	$140,728	*$140,728*
Charity Bot	$0	$51,756	*$51,756*
Total	*$2,750,600*	*$3,867,000*	***$1,116,400***

In addition to creating greater Staff efficiencies, ***automated bots captured $192,000 per month*** in value. The work of bots alone pays for the technology.

In summary, the project aimed to achieve better performance than what could be accomplished by either the in-house staff or the vendor alone.

The increased revenue was a direct result in changing number and mix of accounts handled by the Financial Office and vendor.



The technology helped the financial office perform better:

- **Adjudicated 100% more accounts**
- **Increased Medicaid accounts by 49%**
- **Reduced Self-Pay accounts by 10%**

The improvement in performance resulted from ***more efficient application processing by the financial office***

Applications Completed per Month			
	PRE	POST	*Incremental*
Applications - Medicaid	102	174	71%
Applications - Charity	319	476	49%
Total	421	650	54%

Part of the success of the technology was enabling patients to submit digitally (i.e., from home), **allowing Staff to process applications without the patient present.**

Patients Touched per Month			
	PRE	POST	*Incremental*
In-person	786	1164	48%
Digitally	0	896	*infinity*
Total	786	2060	162%

CONCLUSION

Changing New Jersey policies are creating a greater urgency than ever to ensure efficient and cost-effective solutions for enrolling uninsured patients into benefits programs like Medicaid and Charity Care. In particular, the new budget for New Jersey's Charity Care program is being redirected to Medicaid outpatient.

Automation technology enhances efficiency for Medicaid and Charity Care enrollment processes for both patients and Staff, making it an invaluable tool for protecting revenue.

In the future, this technology platform may be extended in two

important ways:

1. Cover patients in other benefits including government benefits (e.g., WIC, TANF, and SNAP) as well as pharmaceutical benefits (e.g., copay fee reduction) to further protect and enhance revenue.
2. Help patients better understand their benefits to direct them to the appropriate sites of care. This would not only improve patient access, but also improve outcomes while reducing total cost of care .

About the authors

Pedram Afshar is a technology innovator focused on human-centered automation to improve health access, particularly for the underserved. Pedram is currently CEO and Founder of Sage Health and a course instructor at Stanford's "Societal Health Entrepreneurship". Prior to Sage, Pedram has launched products in neuromodulation and cardiac rhythm management at Medtronic and Element Science, respectively. Pedram is trained as a dual medical doctor -- both an MD and a PhD in computer science. He holds an engineering undergraduate from University of Pennsylvania, and a Stanford Fellowship in Biodesign. To start Sage, Pedram personally enrolled over 100 patients in a month from midnight to 3am in a Hospital Emergency Department. Pedram grew up in Manalapan and loves tennis and billiards. He can be reached at pedram@sagehealth.io.

Garrick Stoldt is CFO of Saint Peter's Medical Center. He can be reached at gstoldt@saintpetersuh.com.

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Your Health Care Financing

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NJHCFFA
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Jessica Waite
Capital Asset Program Manager
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Coding Compliance and Risk Mitigation: Strategic Revenue Retention

Nancy Clark

By: Nancy Clark, CPC, COC, CPB, CPMA, CPC-I, COPC, AAPC Fellow

The current economic landscape has tightened healthcare operating margins, making maximizing reimbursements a priority. When addressing revenue retention, financial leaders frequently target expediting claim submissions and effectively addressing denials. Of equal, if not greater importance, is ensuring that revenue received is not lost to future carrier audits.

How the Claims Adjudication Process Contributes to Revenue Risk

Medical claims are adjudicated in "good faith", based on medical codes submitted on the claim form or electronic transmission. Since medical record documentation, which is required to support the medical codes selected, is not usually required, the payer cannot validate code submission accuracy. Most insurance payers will perform periodic audits of randomly selected documentation to confirm whether the medical record supports the codes billed. This process may lead to identification of "improper payments", representing claims that upon retroactive review of medical record documentation, should not have been paid. Improper payments are comprised of both overpayments and underpayments, with each carrying its own set of challenges and opportunities for revenue recovery and compliance.

The issue of improper payments is not trivial; it is pervasive and multifaceted. In 2023, the Department of Health and Human Services reported a staggering $100 billion in improper payments within the Medicare and Medicaid programs (1), while Medicare's Fee-for-Service program alone accounted for an estimated $31 billion, constituting over 7% of payments (2). Add that to the administrative costs associated with recoupment, and those slender operating margins just got thinner.

Strategies for Risk Mitigation and Revenue Optimization

The adage "preparation is the best defense" holds particularly true in the context of these revenue cycle processes. The best defense to carrier takebacks is a proactive approach which includes regular coding and documentation reviews, clinician and staff education, and an understanding of current audit targets.

Ensuring that providers are well versed in clinical documentation requirements, that coding and billing staff are thoroughly trained and their output is reviewed is essential. Such proactive measures can protect a practice against the risks of noncompliance and the resultant financial repercussions.

1. The Value of Coding and Documentation Reviews

Coding and documentation reviews play a crucial role in addressing the educational needs of providers. These reviews can highlight areas where additional training is needed and provide a framework for targeted education. By identifying knowledge gaps and addressing them proactively, healthcare practices can improve their coding accuracy and reduce the risk of costly errors.

2. Education and the Role of Healthcare Professionals

Physicians and nonphysician practitioners typically receive little, if any, education on medical coding and the related documentation requirements. Yet these professionals are responsible for the clinical documentation supporting the medical codes selected.

Compounding this concern is the limited utilization of certified professional coders in many organizations. Not all establishments have certified, experienced medical coders who review every medical record. Depending on the role, coding professionals may be limited to assigning codes. This process does not fully address the core issues, which include the compliance of medical record documentation and its support of pertinent guidelines. Without regular feedback on their documentation, physicians' documentation and compliance are inherently at risk.

3. Staying Ahead of Audit Targets

Knowledge of current audit targets is key to effectively mitigate the risk of audit recoupments. Also necessary is having a deep understanding of current guidelines, carrier regulations,

and requirements of compliant documentation, coding, and billing practices. Areas such as Evaluation and Management (E&M) codes, telehealth services, and medical necessity are currently being scrutinized and should be prioritized.

Maximizing Revenue Through Compliance

Coding compliance and risk mitigation are essential to the financial health of healthcare organizations. By capturing all services rendered accurately and adhering to compliant coding and billing practices, practices can not only diminish financial penalties but also optimize revenue collections. By integrating a culture of compliance into the strategic framework of revenue optimization, practices can safeguard their revenue by transforming a potential obstacle into a competitive advantage.

(1) https://www.gao.gov/products/gao-24-107487
(2) https://www.cms.gov/files/document/2023medicarefee-servicesupplementalimproperpaymentdatapdf.pdf

About the author

Nancy Clark, CPC, COC, CPB, CPMA, CPC-I, AAPC Fellow is with the Eisner Advisory Group. Nancy Clark is a skilled healthcare consultant specializing in revenue cycle process optimization, with substantial experience in medical coding education and auditing. She is highly regarded for conducting coding audits and leveraging the findings to provide tailored education for physicians, coding professionals, and revenue cycle staff. Additionally, Nancy supports providers during insurance carrier coding audits and serves as an expert witness. She has worked in diverse specialties and settings, delivering successful revenue cycle management for large physician groups and hospitals. Nancy can be reached at NancyClarkCPC@gmail.com.

Medicare Provider Enrollment Updates, Challenges, and Potential Penalties for Non-Compliance

Alicia Shickle

By: Alicia Shickle AHFI, CHC, CPC, CPCO, CPMA, CRC, CPPM

In the complex landscape of healthcare, Medicare provider enrollment stands as a critical process that ensures healthcare providers meet specific criteria to bill for services rendered to Medicare beneficiaries. Recent updates, ongoing challenges, and potential penalties for non-compliance highlight the importance of understanding and adhering to these regulations.

Updates in Medicare Provider Enrollment

Medicare undergoes periodic updates to its provider enrollment requirements. These updates are aimed at enhancing transparency, reducing fraud and abuse, and improving the overall quality of care delivered. Key updates often include revisions to application forms, verification processes, and compliance standards.

In recent years, updates have focused on:

1. **Electronic Enrollment -** Moving towards digital platforms to streamline processes and reduce paperwork burden.
2. **Screening Requirements -** Strengthening provider screening to prevent ineligible entities from enrolling.
3. **Revalidation -** Requiring periodic revalidation of provider information to ensure accuracy and compliance.

These updates are essential for maintaining the integrity of the Medicare program and safeguarding beneficiaries' access to quality healthcare services.

Challenges Faced by Providers

Despite the benefits of these updates, healthcare providers encounter several challenges during the enrollment process:

1. **Complexity and Lengthy Processing Times -** The enrollment process can be intricate, requiring meticulous attention to detail and extensive documentation.

2. **Navigating Regulatory Changes -** Keeping up with frequent updates and changes in Medicare policies can be daunting for providers and their administrative staff.

3. **Data Accuracy and Verification -** Ensuring all information provided is accurate and verifiable can be a significant hurdle, leading to delays and potential rejections.

These challenges often necessitate dedicated resources and expertise within healthcare organizations to navigate successfully.

Potential Penalties for Non-Compliance

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Potential Penalties for Non-Compliance

Non-compliance with Medicare provider enrollment requirements can have serious repercussions, including:

1. Payment Denials - Failure to enroll properly or maintain accurate information can result in payment denials for services rendered to Medicare beneficiaries.
2. Revocation of Enrollment - Medicare may revoke a provider's enrollment if they are found to have provided false information or engaged in fraudulent activities.
3. Fines and Civil Monetary Penalties - Monetary penalties may be imposed for intentional or negligent non-compliance with enrollment rules.

Furthermore, providers risk damage to their reputation and potential exclusion from participation in federal healthcare programs, which can severely impact their ability to serve Medicare beneficiaries.

Conclusion

Staying informed about Medicare provider enrollment updates, overcoming associated challenges, and ensuring compliance are vital for healthcare providers aiming to effectively participate in the Medicare program. The evolving regulatory landscape demands vigilance and adaptability from providers to maintain eligibility and uphold the highest standards of patient care. By proactively addressing these aspects, providers can navigate the complexities of Medicare enrollment with greater confidence and mitigate the risks associated with non-compliance.

As healthcare continues to evolve, so too must the processes that govern it. Medicare provider enrollment remains a cornerstone of ensuring access to essential healthcare services for millions of Americans, making adherence to its requirements not just a regulatory necessity, but a commitment to quality and integrity in healthcare delivery.

About the author

Alicia is President of ProCode Compliance Solutions, LLC and has decades of clinical and administrative healthcare experience. Her areas of expertise include revenue cycle integrity, documentation, coding and billing compliance, Medicare, MSP, and Medicaid guidelines and regulations, practice workflow and operations, compliance program assessments, development, and implementation. She can be reached at ashickle@procodecs.com.

New Members

Shrouq AlRawashdeh
Binghamton University
Student
salrawa1@binghamton.edu

Melody Santos
melodysantos.ds@gmail.com

Mark George
RWJ Barnabas Health
Director
mark.george@rwjbh.org

Linda Freda
Hackensack Meridian
Director, Pt Financial Acctg, South
linda.freda@hmhn.org

Paul Mazariegos
RWJ Barnabas Health
Financial Analyst
paul.mazariegos@rwjbh.org

Arya Yao
Rutgers University
PhD Candidate
arya.yao@rutgers.edu

Anthony Whelan
WithumSmith+Brown, PC
Staff II Accountant
awhelan@withum.com

Lyndsay James
Penn Medicine
Associate Director Financial Counseling
No Email

Bryan Hart Columbia University
Administrator
Columbia University
bryan.c.hart@gmail.com

Swetha Ramachandran
EMPClaims Customer Success Manager
swetha.ramachandran85@gmail.com

Allysa Restaino
KPMG LLP
Senior Associate
arestaino@kpmg.com

Stephanie O'Reilly
JEFFERSON HEALTH SYSTEM
Manager - Quality, Safety, & Nursing Data Analytics
smo001@jefferson.edu

Valerie Brooks
vbrooks@montefiore.org

Edward Palmer
edward.palmer@bakertilly.com

Amy Romano
Manager
amy.romano@nemours.org

OluwashinaAliweri
Consultant
oaliweri@guidehouse.com

Diana Di ReWithum
Business Development Executive
ddire@withum.com

Chris Romano
Guidehouse
Managing Consultant
cromano@guidehouse.com

Empowering Healthcare Providers Against Rising Payer Denials

Originally Published on **Healthcare Dive**

By: CorroHealth

In the rapidly evolving landscape of U.S. healthcare, the tug-of-war between payers and providers is continually intensifying, raising the stakes on the strategic maneuvers that shape the industry's financial and operational dynamics. The crux of the issue lies in the increasingly sophisticated strategies employed by insurance companies to deny claims: a move that ostensibly aims to safeguard their bottom lines, often at the expense of provider sustainability and patient access.

The rise in denial rates is more than a mere statistic; it's a symptom of a broader systemic challenge that calls for strategic foresight and robust expertise. In this intricate environment, providers face numerous administrative challenges, working to balance clinical decisions with financial sustainability.

Drawing on extensive analytics, clinical regulatory expertise, and years of experience, addressing payer denial tactics requires a multifaceted approach. Industry trends, including the shift towards value-based care and a focus on patient-centric models, continue to challenge traditional provider business models. Insights into these trends can provide guidance for navigating these changes effectively.

A closer examination of payer denials reveals a pattern of complexity designed to challenge provider resilience. Analyzing the entire denial management process—from claim submission to resolution—can highlight critical areas where targeted interventions can significantly improve outcomes. This includes analyzing denial codes, using predictive analytics to foresee potential issues, and training staff to handle the appeals process adeptly.

Proactive contract management is crucial, emphasizing the need to carefully review terms and negotiate to anticipate and counteract denial strategies. Clear definitions of medical necessity, timely filing limits, and transparent appeal processes are essential elements. By using data-driven negotiation tactics and understanding payer methodologies, providers can better protect themselves against denials.

Enhancing communication between payers and providers is also important. Forums, partnerships, and collaborative efforts can bridge gaps, fostering mutual understanding and respect. This can lead to innovative solutions for ongoing challenges.

Hospitals and health systems need to balance financial sustainability with high-quality patient care. Addressing payer denials and operational challenges while maintaining a focus on accessible, high-quality care is essential. A more productive and transparent dialogue between payers and providers can support a healthcare system where financial and care goals align.

In this context, strategic partnerships are vital for navigating the complexities of healthcare. Understanding the dynamics between payers and providers and fostering innovation can contribute to a more equitable and efficient healthcare system.

The industry stands at an existential crossroads. The insights and strategies shared by CorroHealth serve as a testament to the company's expertise and its dedication to shaping a future where healthcare is accessible, affordable, and effective for all.

About the author

CorroHealth is the leading provider of clinically led healthcare analytics and technology-driven solutions dedicated to positively impacting the financial performance of hospitals and health systems, delivering integrated solutions, proven expertise, intelligent technology, and scalability to address needs across the entire revenue cycle.

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Navigating Compliance: Lessons from Recent Enforcement Activity

Leslie Boles

By: Leslie Boles, BA, CCS, CPC, CPMA, CHC, CPC-I, CRC

This session, "Navigating Compliance: Lessons from Recent Enforcement Activity," offers an in-depth exploration of the recent surge in enforcement actions within the healthcare sector, with a focus on identifying the underlying compliance vulnerabilities that led to these significant penalties. As healthcare organizations face growing pressure to adhere to stringent regulatory standards, understanding these enforcement trends is essential for mitigating risk and strengthening compliance programs. Participants engaged in a thorough examination of real-world case studies, dissecting key compliance failures such as improper coding, billing inaccuracies, and documentation deficiencies. The session revealed how these missteps were identified by regulators and the resulting consequences, providing critical insights into common compliance pitfalls that can affect any healthcare organization.

As healthcare organizations face growing pressure to adhere to stringent regulatory standards, understanding these enforcement trends is essential for mitigating risk and strengthening compliance programs.

Beyond identifying risks, the session informed attendees on developing proactive compliance strategies. Emphasis was placed on building robust auditing and monitoring systems that can detect and address potential issues early. Participants also learned how to foster a culture of continuous improvement, ensuring that compliance efforts are not just reactive but also preventive. The session further addressed the complexities of navigating evolving regulatory landscapes. As rules and guidelines shift, maintaining up-to-date compliance programs becomes increasingly challenging. Practical advice was provided on how to adapt compliance practices to meet new regulatory demands, helping organizations remain agile and compliant.

By drawing lessons from recent enforcement actions, this session equipped healthcare leaders with the knowledge and tools necessary to enhance their compliance frameworks, reduce vulnerability to regulatory scrutiny, and promote a stronger, more resilient organizational culture.

About the author

Leslie Boles is the Co-Owner & President of Revu Healthcare, with over 15 years of experience in healthcare coding, auditing, and compliance. Leslie earned her bachelor's degree from the University of Arizona and is certified by the American Academy of Professional Coders, American Health Information Management Association, and the Health Care Compliance Association. She can be reached at lboles@revuhealthcare.com.

•Who's Who in NJ Chapter Committees•

2024-2025 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	Chair	Co-Chair(s)	Board Liaison	Dates/Time/Access Code	Meeting Location
CARE (Compliance, Audit, Risk, & Ethics)	Fatimah Muhammad fmuhammad@saintpetersuh.com (732) 745-8600 Ext. 8280	Ryan Peoples RPeoples2@virtua.org	Lisa Weinstein lisa.weinstein@bancroft.org (856) 348-1190	First Thursday of the Month 9:00AM Access Code 473803 Call Line (667) 770-1469	Conference Call
Communications/FOCUS	James Robertson jrobertson@greenbaumlaw.com (973) 577-1784		Brian Herdman bherdman@cbiz.com (609) 918-0990 x131	First Thursday of the Month 8:00AM Access Code 868310 Call Line (667) 770-1479	Conference Call
Education	Lisa Weinstein lisa.weinstein@bancroft.org (856) 348-1190	Tara Bogart tara.bgart@pmmconlne.com (704) 618-1531	Kim Keenoy kim.keenoy@bofa.com (732) 321-5935	Second Friday of the Month 9:00AM If interested please contact one of the Chairs	MS Teams meeting
Certification (sub-committee-Education)	Amina Razanica arazanica@njha.com (609) 275-4029		Amina Razanica arazanica@njha.com (609) 275-4029	See schedule for Education Committee	
FACT (Finance, Accounting, Capital & TaxesA)	licia Caldwell alicia.Caldell@bakertilly.com (732) 687-3535	Mia Morse mmorse@matheny.org (908) 234-0011 ext 1380 Robert Es-Haq REsHaq@RUMCSI.org	Josette Portalatin jportal@valleyhealth.com (973) 641-2200	Third Wednesday of the Month 12PM MS Teams: Meeting ID: 250 059 350 262 Passcode: FWDYzW	MS Teams meeting
Institute 2024	Brian Herdman Bherdman@cbiz.com (609) 937-4387	Christine Gordon cgordon@virtua.org (856) 355-0655	Maria Facciponti Facciponti.Maria@gmail.com (973) 583-5881		
Membership Services/Networking	Daniel Demetrops ddemetrops@medixteam.com (845) 608-4866	Ari Van Dine Ari.VanDine@rsmus.com (212) 372-1278	Heather Stanisci Hstanisci@annuityhealth.com (862) 812-7923	Third Friday of the Month 9:00AM Teams	MS Teams meeting
Patient Financial Services and Patient Access Services	Daniel Demetrops ddemetrops@medixteam.com (845) 608-4866	Marco Coello mcoello@affiliatedhmg.com (973) 390-0445	Amina Razanica arazanica@njha.com (609) 275-4029	Second Friday of the Month 10:00AM Access Code 120676 Call Line (667) 770-1453	Conference Call
Payer/Provider Collaboration	Tracy Davison-Dicanto Tracy.Davison-DiCanto@scasurgery.com (609) 851-9371		Lisa Maltese-Schaaf LMaltese-Schaaf@childrens-specialized.org (732) 507-6533	Contact committee for schedule	Contact Committee
Healthcare Current Events Forum	Michael McLafferty michael@mjmaes.com (732) 598-8858		Koy Dever koy.dever@forvis.com 8:00AM (347) 693-4390	Third Wednesday of the Month via Teams (contact committee)	Webex
Regulatory and Reimbursement	Koy Dever koy.dever@forvis.com (347) 693-4390	Gary Stevens gstevens@virtua.org 856-355-0649 ext. 50649	Chris Czvornyek chris@hospitalalliance.org (609) 989-8200	Third Tuesday of the Month 9:00AM Call Line: (732) 515-4266 Phone Conference ID: 670 733 396	MS Teams Call
Revenue Integrity	Tiffani Bouchard tiffani2014@gmail.com (561) 350-0623	Jonathan Besler jbesler@besler.com (732) 392-8238	Jonathan Besler jbesler@besler.com (732) 392-8238	Second Wednesday of the Month 9:00AM via Zoom Join Zoom Meeting: https://zoom.us/j/94907808878?pwd=Sk1nYXdBOFhsdG41TVBoWmVZdytadz09	Zoom
CPE Designation	Lew Bivona lewcpa@gmail.com (609) 254-8141				

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2024 Chapter Internal Financial Review

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

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

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

The internal financial review for the 2023–2024 Chapter Year was completed by the controller of an industry firm. The Chapter Treasurer, the Assistant Treasurer and Officers provided the necessary documentation required for the internal financial review. The completed internal financial review questionnaire was provided to the Chapter's Audit Committee of the Board of Directors. A meeting of the Audit Committee was held to review the findings and the questionnaire. Upon review, the Audit Committee accepted the Internal financial review findings and approved the financial statements for the 2023–2024 Chapter Year.

The accompanying balance sheets and statements of activities and cash flows for the years ended May 31, 2024, 2023 and 2022 reflect the financial statements for the NJ Chapter. If you should have any questions, please feel free to reach out to any Board member for assistance.

Respectfully submitted,

Brian Herdman
2023-2024 Audit Committee Chair
NJ HFMA

Healthcare Financial Management Association - New Jersey Chapter
Balance Sheets

	As of May 31		
	2024	2023	2022
Assets			
Current Assets			
Bank accounts	$ 352,380	$ 371,192	$ 246,995
Accounts receivable, net	10,000	9,839	14,380
Other current assets	9,000	6,908	1,980
Total current assets	371,380	387,939	263,355
Investments	25,483	23,812	24,104
Fixed assets	-	-	-
Total assets	$ 396,863	$ 411,751	$ 287,459
Liabilities and net assets			
Liabilities			
Current liabilities			
Accounts payable	$ 25,239	$ 28,066	$ 168
Deferred revenue	41,567	56,836	2,500
Accrued payroll	-	-	5,684
Total current liabilities	66,806	84,902	8,352
Total liabilities	66,806	84,902	8,352
Net assets			
Thomas G. Shanahan Scholarship Fund	20,390	20,390	1,000
Net assets without restriction	309,667	306,459	278,107
Total liabilities and net assets	$ 396,863	$ 411,751	$ 287,459
	-	-	-

Healthcare Financial Management Association - New Jersey Chapter
Statements of Activities

	Year ended May 31		
	2024	2023	2022
Income			
Meeting and education income	165,595	177,820	106,638
Newsletter income	4,320	5,240	17,220
Golf Outing Income	43,127	45,300	55,475
General sponsorship income	220,658	157,450	189,289
Interest income	7,799	4,087	422
Other income	-	23,390	-
Total income	441,499	413,286	369,044
Expenses			
Meeting and education expenses	346,727	286,932	271,464
Newsletter expenses	7,468	4,537	14,239
Golf Outing expenses	23,032	28,854	30,896
Member recognition and social event expenses	7,778	7,553	6,899
General and administration expenses	54,449	37,127	39,133
Provision for bad debts	-	-	-
Total expenses	439,454	365,002	362,630
Net Operating Gain/(Loss)	2,044	48,284	6,414
Unrealized gain and loss	1,163	(542)	(1,991)
Net income (loss)	3,208	47,742	4,423

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

	Year ended May 31		
	2024	2023	2022
Operating activities			
Net income (loss)	3,208	47,742	4,423
Adjustments to reconcile net income (loss) to net cash provided by (used in) operations:			
Change in unrealized gains (net)	(1,163)	542	1,991
Accounts receivable, net	(162)	4,542	(11,580)
Other current assets	(2,092)	(4,928)	10,267
Accounts payable	(2,827)	27,898	(4,122)
Deferred Revenue	(15,269)	54,336	(12,146)
Accrued Payroll	-	(5,684)	3,727
Net cash used in provided by (used in) operating activities	(18,305)	124,447	(7,441)

Cash flows from Investing Activities			
Purchases of Investment, net	**(508)**	**(250)**	**(227)**
Net decrease in cash	**(18,812)**	**124,197**	**(7,668)**
Cash at beginning of period	**371,192**	**246,995**	**254,663**
Cash at end of period	**352,380**	**371,192**	**246,995**

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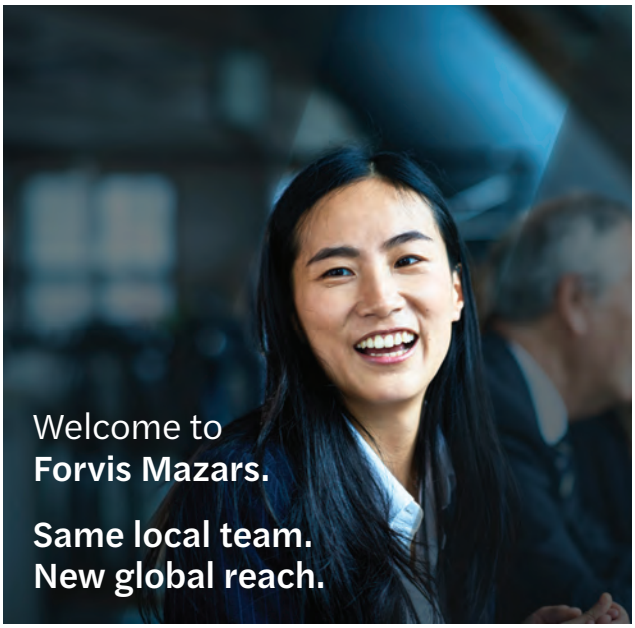

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Everest Group: RCM Platform Peak Matrix Major Contender 2023

KLAS: 89.5 KLAS Customer Ranking for Prior Authorization

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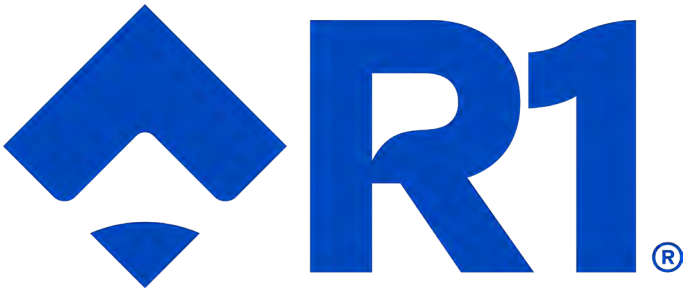

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