Captain Alfredo Fuentes, FDNY, 9/11 First Responder and Survivor

Alfredo Fuentes is a retired Captain of the Fire Department, City of New York. On September 11th, 2001, Fuentes, as acting battalion chief, led a contingent of fireboats on a mission to carry away survivors from the burning World Trade Center Towers. In the midst of coordinating rescuers and pulling wounded firefighters from the wreckage in order to speed them to area hospitals, Fuentes himself was caught in the collapsing rubble as he rushed to search for more survivors in the North Tower. He sustained crushing injuries to his skull, lungs, and ribs and lay pinned beneath a steel girder for over two hours. Capt. Fuentes persevered through prayer, finally managing to radio his comrades and lead them to his position and his eventual rescue.

Captain Al Fuentes' career spans 26+ years of serving New York City and 30+ years specializing in the fields of Emergency Management, Disaster Preparedness, Disaster Response and Recovery, Search and Rescue (member of the NYTF 1 national USAR Team), and Emergency Preparedness. He holds a Bachelor's degree in Psychology and a Master's degree in HLS Leadership in conjunction with the Naval Post Graduate School. Captain Al has been a recipient of 11 meritorious awards as well as a 9/11 meritorious medal for actions during the 9/11 NYC terrorist attacks.

Ilise Zimmerman is the Executive Director of the Partnership for Maternal and Child Health of Northern New Jersey located in Newark, New Jersey. This non-profit is the largest maternal/child health consortium in the State. The Partnership is responsible for analyzing and coordinating obstetric and pediatric services in 8 counties, a region which includes 53% of NJ's births and 24 acute care hospitals. Prior to this position, Ms. Zimmerman was the President and Chief Executive Officer of the Northern New Jersey Maternal/Child Health Consortium, an agency focused on improving the health of medically underserved women and children in four counties within NJ. While at the Northern Consortium, Ms. Zimmerman established the Black Infant Mortality Reduction Resource Center to focus attention and resources on racial disparities in perinatal outcomes. As the Administrative Consultant to the Commissioner of Health's Blue Ribbon Panel on this topic, Ms. Zimmerman orchestrated the work effort, edited and produced the group's ground-breaking report. As a result of this document's findings, former Governor Christie Whitman approved the release of $2 million for a model state-wide campaign, “Black Babies, Better Survival.”

In 2013, Columbia University bestowed its highest level of recognition upon Ms. Zimmerman. She was awarded the Dean Allan Rosenfield MD Alumni Leadership Award. The American Conference on Diversity recognized Ms. Zimmerman's work with their 2011 Humanitarian Award. NJBIZ identified Ms. Zimmerman as a 2011 Healthcare Hero Awardee. Ms. Zimmerman has received the prestigious FDR Award from the March of Dimes and was honored by the New Jersey Women and AIDS Network for her leadership. Ms. Zimmerman was a Fellow with Leadership New Jersey’s class of 2004. Ms. Zimmerman lectures annually at Cornell University’s Sloan program in health administration.

Tyler Enslin is the National Director of Direct Development Training, a company dedicated to providing tailor-made training to help businesses thrive like never before.

With over 200 speaking engagements a year for a multitude of industries, Tyler has received outstanding recognition by those in his audience, which has enabled him to work with state and national agencies across the country. From Fortune 500 companies and large organizations like GlaxoSmithKline, Siemens, Johns Hopkins University, Sinclair Broadcast Group, and Long & Foster, to hundreds of smaller groups and associations, Tyler rarely passes on an opportunity to get his message across.

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A Hospital's Not-For-Profit Status Remains At Risk
As The IRS Confirmed Its First Revocation Under 501(r)
by John W. Kaveney
6

Co-Chair’s Corner
Welcome to the 41st Annual Institute
by Stacey Medeiros
11

Healthcare Reform: Three Steps That Will Help
by John J. Dalton, FHFMA
16

Reframing the Myth of the Glass Ceiling:
How a new Perspective can Help Women Advance
by Dr. Cortney Baker
18

NJ HFMA Webinar Program
19

Effective Written Business Communication
by Jim Grigsby
20

Two-Midnight Hospital Policy Still Creates Compliance and
Revenue Integrity Risk for Hospitals
by Joseph Zebrowicz, MD
22

Bridging the Gap: Understanding the Role of Enterprise
Risk Management during Healthcare Change
by Danette L. Slevinski, JD, MPA, CHC, CHRC, CHPC, CIPM and Timothy J. Fournier, EdD, MBA
24

2017 Institute Schedule at a Glance
30-31

Trends in Federal Healthcare Enforcement Actions &
Tips for Finance and Compliance Executives to Mitigate Risks
by Robert Senska and Jack Wenik
32

Using Advanced Analytics to Get More from your Follow Up Staff
by Peter Angerhofer and Jeff Mean
36

Making Care Affordable Creates Loyalty
by April York
39

Creating a New Mindset – Fully Embracing Revenue Integrity
by Kristi Morris
41

Determining if the Provider-Sponsored Health Plan Path is Right for You
by John Tam and Ken Wood
43

Revenue Integrity Forum Hosts Successful Educational Event
by Betsy Weiss, RN, MPH
45

Chapter Year-end Financials
47-49

Chapter Awards
51

Institute Sponsor Guide
52-57

Sponsors
58-60
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Brian Herdman, Director ................................................................. CBIZ KA Consulting
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OBJECTIVE

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

IDENTIFICATION STATEMENT

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Hello New Jersey HFMA Chapter members!

As the Chapter’s President, I hope that everyone enjoys our 41st Annual Institute Edition of the Garden State Focus.

Our 41st Annual Institute is scheduled for October 4th-6th at the Borgata Hotel in Atlantic City. Our Institute provides attendees with excellent education sessions, vendor demos and various types of networking events. This year’s Institute includes the following:

- Approximately 18 continuing professional educational credits
- On-site certification review and exam sessions for Modules I and Module II of HFMA’s Certified Healthcare Financial Professional program
- Wednesday’s keynote address by Ilise Zimmerman, President and CEO of The Partnership for Maternal and Child Health of Northern New Jersey
- A sports-themed “Pub Night” Networking Reception on Wednesday evening
- Games, prizes and one grand prize on Wednesday evening during our Pub Night Networking Reception to support our Chapter’s designated charities this year: (1) The Partnership for Maternal and Child Health of Northern NJ (2) Central Jersey Family Health Consortium and the (3) Southern New Jersey Perinatal Cooperative.
- Thursday’s keynote address by Captain Al Fuentes, FDNY, a 9/11 First Responder and survivor. Hear his story as he details the events of September 11, 2001, the emergency response and his determination to survive.
- Thursday’s President’s Reception
- Thursday’s late night reception
- Friday morning’s “Healthcare C-Suite Panel” discussion

Thank you to all our sponsors. Without their support, our Chapter could not continue providing its members with such outstanding education sessions and networking events. In addition, I’d like to thank the entire Institute Committee, which has done an outstanding job this year. Note that Brittany Pickell and Heather Stanisci did a terrific job designing our Institute’s marketing material. A special thank you to this year’s Institute Chair and Co-Chairs, Mike McKeever, Stacey Medeiros and Tony Panico. Lastly, a big thank you to Laura Hess, our Chapter’s administrator.

Registration and sponsorship information is located at www.njhfmainstitute.org.

Hope to see everyone at our 41st Annual Institute in Atlantic City!

Best regards,

Scott J. Mariani, JD
President
Keeping a pulse on the myriad changes in healthcare can be a challenging undertaking. In addition to performing our day-to-day responsibilities, all of us need to stay on top of the latest updates from Washington, new technologies in the marketplace and research that leads to changes in the way in which healthcare is provided. The manner in which we provide healthcare has changed drastically over the past generation and will do so again over the next one. However, there is one constant throughout all of these periods of transition: the continual need for professional education.

This month, the New Jersey and Metro Philadelphia HFMA Chapters will host our 41st Annual Institute in Atlantic City. There, attendees will have a number of ways to learn about new developments in healthcare. They’ll have options to attend educational sessions, attain healthcare certifications, learn about new vendor offerings and network with colleagues in the industry. All of these are vital functions in our healthcare careers. Continuing professional education isn’t just for academic purposes but it’s vital in helping us gain expertise at our jobs.

We believe that this edition of the Focus provides numerous opportunities for professional education. This edition highlights a number of best practices that offer avenues to improve the functionality of the revenue cycle and healthcare reimbursement. Peter Angerhofer and Jeff Means have written a provocative piece about how analytics can provide drastically better results for a hospital’s accounts receivables. April York details the significant changes that Novant Health made in communicating patient responsibility and how their efforts improved customer satisfaction and reduced bad debt. Angerhofer, Means and York will also be speaking at the Institute.

This edition also highlights important news emanating from Washington. Two articles are included about a new action taken by the Internal Revenue Service. The organization recently revoked a tax-exempt status from an acute care hospital. This change has a profound effect on our industry, including the safety of non-profit foundations and the potential introduction of new taxes on healthcare providers. Two articles in the magazine detail other changes and trends originating from Washington, including the Two-Midnight Rule and federal healthcare enforcement action under the Trump Administration.

“Perspectives in Healthcare,” is a new column that will be featured on the back inside page of the magazine. The column will highlight issues of importance to New Jersey healthcare leaders. In this edition, Tara Adams Ragone details the importance of behavioral health parity. As stakeholders in the healthcare community, we have a unique opportunity to effect change in this area as it continues to be debated on the state and federal levels.

Although we all understand the importance of professional education, we know that learning can also be most effective when it’s interactive. One of the best ways to pick up valuable knowledge about the industry is through our peers. The NJ HFMA Chapter provides numerous committees that also serve as avenues for professional (and often, personal) enrichment. Our committees are fantastic ways to gain valuable knowledge about our industry and further increase our professional networks. See page 14 for a list of committee meetings.

We hope that you enjoy the Institute. Every year the Institute staff works tirelessly to provide the right mix of educational opportunities, intellectual curiosity and plain old fun, and they do a fantastic job. Thank you to all the committee chairs and volunteers for putting their time and effort into making this conference into the staggering success that it has become.

We look forward to seeing all of you in Atlantic City.

About the Authors

Adam Abramowitz is a senior manager for sales and marketing at CBIZ KA Consulting Services, LLC in East Windsor, NJ. Prior to working in healthcare, Adam was a policy coordinator and speechwriter for several South Jersey political campaigns and administrations. He graduated with degrees in political science and creative writing from Emory University and an M.B.A. from Temple University. A Cherry Hill native, Adam currently resides in Philadelphia where he enjoys playing guitar, hiking, hockey and watching classic movies.

Brian Herdman is an operations manager in financial reimbursement services for CBIZ KA Consulting Services, LLC in East Windsor, NJ. Brian has a degree in chemistry from Princeton University and an M.B.A. from Rutgers University. When not poring over Medicare regulations or claims data, Brian is keen on traveling near and far with his wife, rooting for his hometown teams from Pittsburgh and tasting and preparing as many barbecue styles as he can find.
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A Hospital’s Not-For-Profit Status Remains At Risk As The IRS Confirmed Its First Revocation Under 501(r)

by John W. Kaveney

In the wake of the New Jersey Tax Court’s decision in AHS Corp., d/b/a Morristown Memorial Hospital v. Town of Morristown, the certainty of a hospital’s tax-exempt status has been placed into question. Now, with the first confirmed revocation by the IRS of tax-exempt status under Section 501(r), hospitals have one more reason to be particularly diligent in their efforts to comply with the IRS requirements to ensure that their tax-exempt status won’t be challenged.

What Is Section 501(r)?

As part of the Patient Protection and Affordable Care Act (ACA), the federal government instituted Section 501(r) of Internal Revenue Code and thereby imposed new requirements applicable to charitable tax-exempt hospitals. Section 501(r) created new requirements for hospitals to maintain their 501(c)(3) tax-exempt status. In particular, it requires that the hospital meet the (1) community health needs assessment requirements, (2) financial assistance policy requirements, (3) requirements on charges and (4) billing and collection requirements, all of which are further defined in the ACA.

For purposes of the community health needs assessment, Section 501(r) requires a hospital to have conducted a community health needs assessment in that taxable year or in either of the two preceding taxable years and adopt an implementation strategy to meet the community health needs identified through the assessment. Moreover, the community health needs assessment must take “into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health” and be “made widely available to the public.”

With regard to the financial assistance policy, the hospital must establish a written financial assistance policy that includes eligibility criteria for financial assistance, the basis for calculating amounts charged to patients, the method for applying financial discounts, the actions taken in the event of non-payment and measures to publicize the policy within the community. There must also be a written policy requiring the hospital to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility for financial assistance.

A hospital meets the requirements to limit charges by ensuring that there is a prohibition on gross charges and that the amounts charged for emergency or other medically necessary care provided to those eligible for assistance under the hospital’s financial assistance policy is limited to no more than the amounts generally billed to individuals who have insurance covering such care.

Finally, with regard to the billing and collection requirements, a hospital is in compliance if it does not engage in extraordinary collection actions before making reasonable efforts to determine whether the individual is eligible for assistance under the hospital’s financial assistance policy of the hospital.

As part of the Patient Protection and Affordable Care Act, the federal government instituted Section 501(r) of Internal Revenue Code and thereby imposed new requirements applicable to charitable tax-exempt hospitals.

The IRS’s Recent Action Against One Unidentified Hospital

On February 14, 2017, the IRS issued a tax status letter
revoking the tax-exempt status of a “dual status” 501(c)(3) hospital operated by a “local county governmental agency.” The letter was only recently made public on the IRS website in August 2017 and does not identify the particular hospital’s name. However, the determination is likely to result in a loss by the hospital of the use of certain employee benefit plans, a bar on the receipt of tax-deductible contributions, disallowance of any tax-exempt bonds and likely property, income and other tax liabilities.

Among the reasons for the IRS’s action against the unidentified hospital was the facility’s failure to make its community health needs assessment widely available through its website. Furthermore, the unidentified hospital conceded that it had not drafted nor adopted an implementation for at least some of the recommendations included in its implementation strategy report. Ultimately the IRS deemed the unidentified hospital’s conduct to be egregious, though the tax status letter suggested the unidentified hospital was not too concerned about maintaining its tax-exempt status.

The IRS’s actions should come as no surprise to anyone in the healthcare industry. The IRS’s 2017 Work Plan identified the Internal Revenue Code Section 501(r) as an emerging issue on which the IRS intended to begin focusing in its examinations. In the Work Plan, the IRS identified how as of September 30, 2016 it has already reviewed 968 hospitals and referred 363 hospitals for field examination. Surprisingly, the most common issues noted by the IRS warranting a field examination were not hyper-technical violations or obscure regulations but instead basic deficiencies such as the lack of a community health needs assessment, the failure to create financial assistance and/or emergency medical care policies, and the failure to meet the billing and collection requirements.

How Does This Impact My Hospital?

Although the unidentified hospital may not have been concerned about maintaining its tax-exempt status, the many hospitals that do wish to maintain such status must be vigilant and diligent in ensuring that they have the requisite written policies, procedures and statements in place to comply with the specific requirements of Section 501(r). In addition, with the IRS’s issuance of final regulations clarifying certain requirements set forth in Section 501(r) and its corresponding regulation, but they must also ensure that the materials are adequately posted on their websites. Careful attention should be placed on ensuring that all of the requirements are appropriately met as the IRS will be unlikely to ignore a deficiency somewhere in a hospital’s compliance efforts.

About the Author

John W. Kaveney is Of Counsel in the healthcare practice of McElroy, Deutsch, Mulvaney & Carpenter, LLP. He can be contacted at jkaveney@mdmc-law.com.

Footnotes

4http://src.bna.com/i8H
What Hospitals Need to Know About IRC §501(r)

By Smita Baliga

Q. The IRS in its fiscal year 2017 Work Plan described the ongoing review of hospitals and their requirements under the Patient Protection and Affordable Care Act. The Work Plan stated that as of June 30, 2016, 692 hospitals were reviewed to ascertain compliance with these additional requirements and 166 hospitals were referred for field examination. The Work Plan noted that the IRS was going to continue to make the IRC §501(r) compliance review a priority in 2017. What steps can a tax-exempt hospital take to ensure no adverse consequences as a result of these review and examinations?

A. The IRS issued on February 14, 2017 a Final Adverse Determination Letter (“Letter”) revoking the tax-exempt status of a hospital (“Hospital”) recognized as tax-exempt under Internal Revenue Code (“IRC”) §501(c)(3) for its failure to comply with IRC §501(r)(3), the requirement to conduct a community health needs assessment (“CHNA”) once every three years.

IRC §501(r) Background

The Patient Protection and Affordable Care Act, more commonly known as the Affordable Care Act (“ACA”), signed into law by President Obama on March 23, 2010, introduced IRC §501(r) which includes four new requirements with which tax-exempt hospital facilities are required to comply:

- Community Health Needs Assessment (IRC §501(r)(3));
- Financial Assistance Policy (IRC §501(r)(4));
- Limitation on amounts charged to individuals eligible under the organization’s financial assistance policy for emergency or other medically necessary care (IRC §501(r)(5)); and
- Billing and collection practices (IRC §501(r)(6));

IRC §501(r)(3)

A tax-exempt hospital organization meets the requirements of IRC §501(r)(3) if it has conducted once every three years for tax years beginning on or after March 23, 2012 it has conducted a CHNA that meets the code’s requirements.

In addition, the hospital organization must have an authorized body adopt a written implementation strategy to meet the needs identified in the CHNA. Under the final regulations, the implementation strategy is a written plan that, with respect to each significant health need identified through the CHNA, that either:

- Describes how the hospital facility plans to address the health need; or
- Identifies the health need as one the hospital facility does not intend to address and explains why the hospital facility does not intend to address the health need.

The CHNA must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge or expertise in public health, and be made widely available to the public.

IRC §501(r)(4)

IRC §501(r)(4) requires a tax-exempt hospital organization to have a written financial assistance policy (“FAP”) for its hospital facility(ies), which must:

- Apply to all emergency and other medically necessary care provided by the hospital facility or any other substantially-related entity;
- Be widely publicized;
- Include the following six components:
  - The eligibility criteria for financial assistance and whether such assistance includes free or discounted care;
  - The basis for calculating amounts charged to patients;
  - The method for applying for financial assistance; and

IRC §501(r)(5)

IRC §501(r)(5) requires that a tax-exempt hospital organization limit the amounts charged to an individual eligible under the organization’s financial assistance policy for emergency or other medically necessary care. The limitation must be based on the individual’s income and resources, and the method for applying the limitation must be widely publicized.

IRC §501(r)(6)

IRC §501(r)(6) requires that a tax-exempt hospital organization adopt written billing and collection practices that are consistent with the organization’s financial assistance policy. The practices must include the following:

- The method for calculating amounts charged to patients;
- The method for applying for financial assistance; and
- The method for communicating with patients regarding their financial assistance eligibility.

IRC §501(r)(7)

IRC §501(r)(7) requires that a tax-exempt hospital organization adopt written practices for the sale of time, space, or other facilities or privileges, which must be widely publicized and consistent with the organization’s financial assistance policy.

IRC §501(r)(8)

IRC §501(r)(8) requires that a tax-exempt hospital organization adopt written practices for the sale of time, space, or other facilities or privileges, which must be widely publicized and consistent with the organization’s financial assistance policy.

IRC §501(r)(9)

IRC §501(r)(9) requires that a tax-exempt hospital organization adopt written practices for the sale of time, space, or other facilities or privileges, which must be widely publicized and consistent with the organization’s financial assistance policy.

IRC §501(r)(10)

IRC §501(r)(10) requires that a tax-exempt hospital organization adopt written practices for the sale of time, space, or other facilities or privileges, which must be widely publicized and consistent with the organization’s financial assistance policy.
In the case of an organization that does not have a separate billing and collections policy, the actions the organization may take in the event of non-payment;

- Any information obtained from other sources other than an individual seeking financial assistance that the hospital facility uses, and whether and under what circumstances, and

- List of providers, other than hospital staff, delivering emergency or other medically necessary care in the hospital facility that specifies which providers are covered by the hospital’s FAP and which are not. This requirement is outlined in IRS Notice 2015-46.

A hospital facility must also have a plain-language summary, which is a written statement that notifies an individual that the hospital facility offers financial assistance under its FAP and provides additional information in a clear, concise and easy-to-understand manner.

IRC §501(r)(5)

A hospital organization meets the requirements of IRC §501(r) (5) only if the hospital facility, or any other substantially related entity, as defined in the regulations, limits the amounts charged for care that it provides to an individual eligible for financial assistance under its FAP.

A hospital facility must limit the amount charged for any emergency or other medically necessary care it provides to a FAP-eligible individual to not more than the amounts generally billed (AGB) to individuals with insurance covering that care. In addition, a hospital facility must limit the amount charged for any medical care it provides to a FAP-eligible individual to less than the gross charges for that care.

IRC §501(r)(6)

A hospital facility may not engage in extraordinary collection actions (“ECAs”) against an individual before making reasonable efforts to determine whether the individual is FAP-eligible.

A hospital facility will be considered to have engaged in ECAs against an individual if the hospital facility engages in ECAs against any other individual who has accepted or is required to accept responsibility for the first individual’s hospital bills.

Furthermore, a hospital facility will be considered to have engaged in an ECA against an individual if any purchaser of the individual’s debt or any debt collection agency or other party to which the hospital facility has referred the individual’s debt has engaged in an ECA against the individual.

Facts and Determination

The hospital that had its tax-exempt status revoked is a “dual status” entity since it is recognized by the IRS as tax-exempt under IRC §501(c)(3) and also qualifies as a governmental unit or as an affiliate of a governmental unit pursuant to Revenue Procedure 95-48. The hospital is also known as a “Disproportionate Share Hospital,” which is designated by Medicare as a “critical care access facility” for Medicare billing purposes.

The hospital had its CHNA conducted by the National Rural Health Resource Center to meet the requirements imposed by Medicare, not for the intent of complying with the ACA. After the CHNA was completed, the hospital did not post it to its website thus making it widely available to the public claiming that they had the CHNA in paper and made it available upon request. In addition, the hospital never drafted or adopted an implementation strategy.

Pursuant to interviews held by the IRS during its audit, the administrators of the hospital indicated that it did not need to be tax-exempt under IRC §501(c)(3) and “as a small rural facility, had neither the financial wherewithal nor the staffing to devote to the specific requirements of Treasury Regulation §1.501(r)-3 for conducting a proper Community Health Needs Assessment every three years.”

In its letter, the IRS stated the adverse determination was made for the following reason:

“You are a hospital organization which failed to comply with the requirements of IRC §501(r), to conduct a community health needs assessment, adopt an implementation strategy and make it widely available to the public.”

Form 886A, Explanation of Items, is used by the IRS following a review to outline the issue(s) being faced by a taxpayer, the specific facts related to the taxpayer and the IRS review, a summary of the related law and the government’s position. In its Form 886A with respect to this case, the IRS noted that the hospital did not complete and adopt a written implementation strategy; nor did it make its CHNA widely available to the public.

continued on page 10
Moreover, since the administrators of the hospital indicated that the facility did not need to be tax-exempt and that it did not have the financial wherewithal or the staff to comply with IRC §501(r)(3), the IRS, in making its adverse determination, states that “Consequently, (hospital’s) failure to meet the requirements §1.501(r)-3 is considered willful. Especially in light of the fact that the organization expressed on several occasions that they did not need to be exempt under IRC §501(c)(3) and that this status at times actually got in the way of their ability to be involved in various Medicare reimbursement programs.”

**Conclusion**

This revocation of tax-exempt status by the IRS is a significant event in the IRS’s continuing efforts to ensure tax-exempt hospital facilities are complying with IRC §501(r). It is extremely important for tax-exempt hospital facilities to be compliant with all aspects of the final regulations. Otherwise, tax-exempt hospital facilities can face adverse consequences such as the imposition of excise taxes or, potentially, as in this case, loss of tax-exempt status.

**About the Author**

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Co-Chair’s Corner
Welcome to the 41st Annual Institute

by Stacey Medeiros

On behalf of the Annual Institute Committee, welcome to the 41st Annual Institute! We’ve got a jam-packed agenda for the two-and-a-half-day conference. Here’s your guide to the can’t miss events:

Education
Attendees have the opportunity to collect 18 CPEs over the course of the event. Breakout sessions will be available on both Wednesday and Thursday. We’ve also got exciting keynote speakers each day of the conference:

- **Wednesday, 1:15 p.m.** – Ilise Zimmerman, Executive Director of the Partnership for Maternal & Child Health of Northern NJ, will discuss the works of our featured charity for this year’s event.
- **Thursday, 9:50 a.m.** – Captain Al Fuentes, FDNY, a 9/11 First Responder and survivor. Hear his story as he details the events of September 11, 2001, the emergency response and his determination to survive.
- **Friday, 9:00 a.m.** – Tyler Enslin, who will teach us memory retention techniques in a fun, engaging presentation.

Our general session offerings for this year include the 2017 Regulatory Update presented by Michael McLafferty, an update on healthcare reform efforts from John Dalton, a discussion on women’s leadership from Dr. Cortney Baker and a session on data analytics from Asha Saxena.

The ever-popular lunch and learn sessions will also return this year. On Wednesday, Jim Grisby will provide a seminar on improving your written business communications. Thursday, attendees can pick from two lunch and learn sessions, one discussing social media strategies and another on creating a revenue integrity culture. **Please note attendance at these sessions is limited. Arrive early to secure your spot!**

Finally, we’ve revamped the Friday morning panel from a CFO panel to a C-suite panel to give attendees the opportunity to hear from leadership across the spectrum. The panel will feature Gui Valladares, M.B.A., Chief Financial Officer, Princeton HealthCare System; Jeffrey LeBenger M.D., Chairman & CEO Summit Medical Group, Summit Health Management; Theresa Larivee, Chief Executive Officer, Pennsylvania Hospital and Anthony J. Mazzarelli, M.D., J.D., M.B.E., Chief Physician Executive, Cooper University Health Care.

Certification Training and Testing
Have you been wanting to become a Certified Healthcare Finance Professional (CHFP) but can’t find the time? Here’s your opportunity to leave the Institute fully certified. We will offer a certification training course and testing in a group setting during the Wednesday and Thursday breakout sessions. **Attendees must pre-register for these special sessions (limited seats are available)** and study guide materials can be secured at a 20% discount. Contact Amina Razanica for details at arazanica@njha.com or go to the New Jersey HFMA website, www.hfmanj.org. And don’t forget – both the New Jersey and Philadelphia chapters offer full reimbursement of all exam fees upon successful completion of the exams!

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

- **Wednesday Night – Charity Event (5:30 p.m. – 8:00 p.m., Vendor Hall)** – This year’s charity event will be raising money for three organizations: Partnership for Maternal & Child Health of Northern NJ, the Central Jersey Family Health Consortium and the Southern New Jersey Perinatal Cooperative. All three charities work with acute care hospitals in New Jersey to increase access to quality prenatal care. The theme of this year’s charity event is “Sports Bar” and we encourage you to wear your favorite sports team jersey. We’ll feature games such as darts and shuffleboard and light pub fare to snack on. And of course, our charity auction will be held, featuring great prizes courtesy of our vendors. The event will wrap up no later than 8:00 p.m. to ensure that attendees have time for dinner with friends and colleagues.

continued on page 12
continued from page 11

• **Thursday Night – President’s Reception (6:00 p.m. – 8:00 p.m., NEW Central Conference Center)** – This year we are taking advantage of recent renovations at the Borgata and are moving our President’s Reception to the new Central Conference Center. The new space is located near the Wolfgang Puck restaurant (refer to the map in your conference bag for directions) and provides our reception with a more spacious, private space on an upper level. Entertainment will be provided by Jimmy of Jimmy and the Parrots, a Jimmy Buffet tribute band.

• **Thursday Night – Late Night Event (10:00 p.m. – 1:00 a.m., Premier Nightclub)** – Join Jimmy and the Parrots for a Caribbean-themed late night party. Dance the night away with a margarita!

**Free Headshots**
Is your professional photo outdated? Take advantage of free headshots offered at the Institute courtesy of Steve Aaron at HBCS.

**Prizes, Prizes, Prizes!!!**
As mentioned above, attendees have the chance to win prizes at our charity auction on Wednesday evening. This year we’re giving you even more chances to win big prizes throughout the event!

• **Sponsor BINGO** – As usual, we will have our sponsor BINGO for those attendees that visit our valued sponsors throughout the event. This year we will offer iPads for the winners of our Sponsor Bingo, rather than free registration to the 2018 Annual Institute.

• **VISA Gift Cards** – Join us at the 4:00 p.m. general session on Thursday (Dr. Cortney Baker) where we will be raffling off three VISA gift cards at the end of the session. Attendees will receive a raffle ticket upon entrance to the session. You must be present to win!

• **Mystery Bag of Cash** – Who doesn’t like cold, hard cash? We’re going to be raffling off a bag of cash at the end of our Friday education events. As with Thursday’s raffle, attendees will receive a raffle ticket at the beginning of the morning and you must be present for the drawing to win. How much cash is in the bag? You’ll have to be the winner to find out!

**Vendor Demos**
Once again this year we’ll be having the Vendor Demos, which allow our sponsors to showcase their products and services in a more relaxed atmosphere to both current and potential clients. As in prior years, these sessions will be held during lunch on Wednesday and Thursday in the boardrooms. Lunch will be available outside of the boardrooms for all attendees. Please stop by and support our valued sponsors.

Some of the sponsors who will be participating, along with their offerings, are:

**MediTract/MD Buyline**
**Wednesday, 12:35pm – Board Room 2**
**MEDITRACT PROCESS MANAGER™**
MediTract’s Process Manager is the gold standard in contract life cycle management solutions.
This is the only healthcare-specific, enterprise software solution to enable compliant contracting processes and end-to-end workflow management.
Process Manager’s SaaS platform is built on the expertise of MediTract’s healthcare specialists and best-in-class technology to deliver an end-to-end workflow solution that spans contract origination to termination. The software can be configured to fit your health system’s compliant standards, plus easily adapts in real time to meet the demands of the ever-changing regulatory environment and system users within your hospital.
MediTract’s Process Manager enables you to not only mitigate risks, but also to identify areas of opportunity for operational inefficiencies and financial improvements. In addition, Process Manager empowers you to implement process and policy controls critical to patient care.

**WithumSmith+Brown**
**Thursday, 12:30pm – Board Room 1**
**Healthcare + Microsoft Office 365**
**Meet Compliance Needs and Bolster Communications**
Health organizations today are relying more than ever on technology and data to drive efficiencies, improve internal communication and gain intelligence. At the same time, organizations need to focus on diverse healthcare missions: improving quality of care and patient engagement, as well as staying competitive through leading-edge innovation and research. So how can you ensure your technology supports these goals? By using Microsoft Office 365.
Microsoft Office 365 is a suite of collaboration and productivity tools that can be integrated to: create a powerful collaboration space for healthcare staff, use voice and video-conferencing to share documents, confer with each other, meet with and diagnose patients, and use Instant Messaging to reach each other at a moment’s notice. Even more, you can access any of these tools from any mobile device. All of this while ensuring data compliance.

Join WithumSmith+Brown for this exciting demo to see how Microsoft Office 365 and Azure are making a huge impact in the healthcare industry.

We’ll discuss:
➤ Healthcare industry common challenges
➤ Cybersecurity and compliance in the cloud
➢ Digital transformation stories of some of our healthcare clients

This demo session will be interactive with plenty of opportunity to ask questions. BONUS—In addition to gaining insight into the power of the Microsoft Cloud, all attendees have a chance to win one of three $50 VISA gift cards!

Colburn Hill
Thursday, 1pm – Board Room 1
Ops Center
Most providers are not staffed to work 100% of their AR and wind up under-resourcing, or ignoring altogether, a majority of their claim volume, particularly those with lower balances.

Ops Center is a suite of tools built to comprehensively manage the full book of provider AR, providing insight and action on claims of all balances.

Utilizing 90 data points gathered about each specific claim in your AR -- including charges, coding choices, billing status, current payer, remittance history, and any payments or adjustments -- Intel uses over 2,000 business rules to interpret the history and current status of each claim. Using those inputs, Intel determines both the likelihood of collection and the appropriate next steps to collect each individual claim.

Based on that analytical insight, Ops Center determines the best method for pursuing collection, including:

Resolve – where possible, Robotic Process Automation automatically takes action on claims, eliminating those with no collection opportunity and actually performing follow up tasks without any staff time or attention.

Hints – based on claim characteristics, users are provided guidance on the best follow up step to maximize collection opportunities, focusing the staff on action rather than a lengthy review of claim history.

Priority – simple worklisting that groups like accounts and manages the work flow to follow up reps, while providing robust managerial tools to track the actions of each user, noting their individual productivity, efficiency, and effectiveness.

Colburn Hill will be hosting a raffle for attendees of their vendor demo with a grand prize of a $75 American Express gift card; smaller prizes will include a Starbucks gift card, a bottle of wine, and a Dunkin’ Donuts gift card.

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

Please enjoy this year’s Institute!
2017-2018 Chapter Committees and Scheduled Meeting Dates

*NOTE: Committees have use of the NJ HFMA conference call line. The call-in number is (515) 739-1015. 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 with committee chairs before attending.
The Devil Opportunity is in the Detail.

You have data. You need insight.

CBIZ KA Consulting Services, LLC

- Financial Modeling
- Clinical Benchmarking
- Revenue Integrity
- Eligibility and DSH Services
- Charge Evaluation
- Risk Reduction (RAC)

Information. Not Intuition.
Healthcare Reform: Three Steps That Will Help

by John J. Dalton, FHFMA

Missing from both the House and Senate debates on healthcare reform were proposals to attack the real elephant in the room – increasing healthcare costs. In 2015, the U.S. spent $9,507 per capita on healthcare. France, Germany and the United Kingdom spent $4,407, $5,267 and $4,003, respectively. Each country uses a different approach to universal healthcare (France – Two Tier; Germany – Insurance Mandate; United Kingdom – Single Payer), yet all three countries provide better care at half the cost of the U.S. Their citizens live longer and enjoy better health.

With the typical adult American incurring health care costs averaging about $800/month, the challenge of designing affordable health insurance plans is clear. It’s little wonder that high deductible health plans have become so prevalent. We need to find ways to provide better care at lower cost. Here’s my proposal for a three-point plan that ordinary Americans and their representatives can unite around to “Make American Healthcare Great!”

1. Medicare for More Americans – allow adults under age 65 with preexisting conditions to enroll early in Medicare. This would alleviate the fear of job loss, the “age tax” and access to affordable health insurance for millions of Americans. Administered by private-sector contractors Medicare is the most efficient insurer in America, spending 97% of premiums on care, compared with only 80-85% for commercial insurers. It’s not free – beneficiaries do pay premiums and are subject to co-pays, deductibles and coinsurance. The Kaiser Family Foundation estimates that 27% of the 162.7 million American adults under 65 have preexisting conditions. Potential 10-year savings could be as much as $585 billion.

2. Obtain Competitive Prices for Prescription Drugs – Unleash the free market - let patients order prescription drugs from Canada and let Medicare negotiate for competitive drug pricing. Why can’t America’s largest insurer pay prices similar to France, Germany and the UK? Why can’t Americans order their prescription drugs from our neighbor to the north? The prohibitions are absurd. Potential 10-year savings: hundreds of billions, with much of the savings accruing to ordinary Americans who no longer would have to choose between paying utility bills or filling their prescriptions.

3. Incentivize Medical Students to Choose Primary Care Specialties – The Health Resources & Services Administration has projected a shortage of 20,400 primary care specialists by 2020, and there aren’t enough physician extenders to fill the gap. In France, Germany and the UK, roughly 2/3 of physicians are in primary care; in the U.S., it’s less than half. Why? In 2015, 79% of medical students graduated with more than $100,000 in student loan debt and a median debt amount of more than $180,000. So, they compete to enter higher-paying specialties in order to increase their ability to quickly pay down that debt. Why not forgive a portion of their debt for each year in a primary care specialty? Cost savings: None initially; tens of billions long term. Benefits: better health through primary care prevention and wellness initiatives.

When Congress resumes deliberations in the fall, I hope that they will honor Senator John McCain’s recommendation: “Let the Health, Education, Labor, and Pensions Committee under Chairman Alexander and Ranking Member Murray hold hearings, try to
report a bill out of committee with contributions from both sides. Then, bring it to the floor for amendment and debate, and see if we can pass something that will be imperfect, full of compromises, and not very pleasing to implacable partisans on either side, but that might provide workable solutions to problems Americans are struggling with today.”

After years of divisiveness, why not try working together to provide better care at lower cost and “Make American Healthcare Great!” It’s what all Americans deserve.

About the Author
John J. Dalton, FHFMA, is Senior Advisor Emeritus at Besler Consulting, a former Chapter President, National Board member and HFMA’s 2001 Morgan Award winner for lifetime achievement in healthcare financial management. He is a member the Strategic Planning Committee at St. Joseph’s Healthcare System and an Honorary Trustee at Children’s Specialized Hospital where he serves on the Finance Committee. The New Jersey Hospital Association named him its 2017 Hospital Trustee of the Year.

•Focus on...New Jobs in New Jersey•

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

[Note to employers: please allow five business days for ads to appear on the Web site.]

Job Position and Organization

Director of Patient Access  
University Radiology

LTC Patient Account Biller  
CentraState Medical Center

Financial Analyst  
Saint Michael's Medical Center

Financial Analyst II /Senior Accountant  
Children's Specialized Hospital

Accting Manager  
Children's Specialized Hospital

Director of Budget and Analytics  
Community Medical Center

Reimbursement Manager  
AtlantiCare
Reframing the Myth of the Glass Ceiling: How a New Perspective can Help Women Advance

by Dr. Cortney Baker

Women have made substantial advancements when it comes to achieving leadership positions in the workforce today. In fact, women currently account for more than 51% of all management, professional, and related occupations in the U.S. (U.S. Department of Labor, Bureau of Labor Statistics, 2016). However, when it comes to the positions of the highest paid executives (such as chief executive officers) of Fortune 500 companies, women only comprise 5.8% of those roles.

The same holds true with regard to the healthcare industry, a division of the American workforce that is approximately 75% female. Women continue to be the minority among executive-level leadership roles, with only 11% of CEOs in healthcare being female (American College of Healthcare Executives (ACHE), 2012).

A 1986 article by Hymowitz and Schellhardt was published in the Wall Street Journal seemingly giving an answer as to why top-level leadership positions appeared to be explicitly denied to women. This phenomenon was coined the glass ceiling to describe the invisible limits established in the working world that prevent women from advancing to positions of higher-level leadership.

In terms of climbing the corporate ladder into higher-level executive roles, the ceiling indicates the presence of a barrier, standing in the way of how high a person can advance. To describe the ceiling as glass means that the barrier is transparent—not apparent to the observer but very real. The concept of a glass ceiling is typically used in business situations where it is considered, whether rightly or not, that white men are firmly situated in the upper ranks of organizational leadership and that breaking through to that level is practically impossible for women or minorities (Boyd, 2012).

As an American society we have generally accepted the notion of the existence of a glass ceiling—not that the acceptance is an approval of the circumstances, but an acceptance of the idea that invisible forces work against employment advancement of women and minorities.

I am a researcher and I am fascinated with gender studies, particularly in the workplace. Although I am not able to comment on workplace issues with regard to ethnicity, I have spent the last two years conducting doctoral and post-doctoral research on the advancement of women in the workforce. My conclusion: the glass ceiling, as it has been defined, is a myth; and the acceptance of the idea that invisible forces hold us back actually contributes to our lack of progress.

Now, that’s not to say that at one time blatant forces didn’t exist to contribute to the lack of women’s advancements. Or to not give honor and appreciation to the female pioneers who boldly stood up and paved the way for women’s rights, mine included, because I am very grateful that they took a stand for me and my freedoms. However, I do not believe that invisible forces are responsible for the shortage of women in executive-level roles. I have conducted the research and I know the contributing forces aren’t invisible. I can name them; they are real.

As a result, I believe we must consider our barriers to be penetrable and surmountable for us to succeed. Think about it, if you consider the design and function of a ceiling, you’ll see it’s an object not intended to be penetrated. There’s really no reason to get beyond it—why would you want to? And the fact that the ceiling is glass infers the presence of a see-through, almost invisible barrier. Therefore, by buying into the belief that we are fighting invisible challenges not meant to be won means we are buying into a myth… the myth of the glass ceiling.
However, if we look at our journey and challenges as a labyrinth, or maze, our perspective changes. The whole objective of a maze is to persevere at each turn, shift, and twist, knowing that there will be times that we hit dead-ends and bumps in the road, but staying the course until the end is reached. When we know what obstacles and challenges we’re facing, we can arm ourselves to persist and endure, succeeding to the finish line.

And in this case, the end would be higher-level leadership positions, if that is the level you decide is right for you. If we begin to look at our career paths through a slightly different lens, then we have the amazing opportunity to be successful—to CONQUER. My desire is that we all start to look at our journeys through the eyes of a kindred tribe, banded together to conquer the executive level. This, in my opinion, is certainly better than viewing ourselves as sojourning alone believing it’s every “man” for himself against some imaginary object intended to hold us down.

Therefore, I propose we have a new objective. Our goal shouldn’t be to break through a glass ceiling, but to persist and overcome the challenges that inevitably lie before us, and triumph. I’m confident that we hold the keys to unlocking the corner office doors, if we so choose. Please join Dr. Baker for her presentation, “The Alliance Effect” on Thursday, October 5th, at 4p.m. in the ballroom.

About the Author

Dr. Cortney Baker is a business owner, speech therapist, author, leadership expert, entrepreneur, speaker, wife, mother of three, and proud native Texan. Dr. Baker is owner and CEO of Kids-Care Therapy, a pediatric home healthcare agency that employs approximately 300 people and helps assist over 2200 children all over Texas and Colorado. She also opened Baker Management Group, a firm where she enjoys consulting and speaking nationwide. She was honored to be named a finalist for Texas Business Woman of the Year for 2014-2015 and 2015-2016. She can be reached at cortney@cortneybaker.com.

NJ HFMA Webinar Program

You asked We answered. Many members asked for easy access to education at a reasonable cost. We answered with a webinar program that includes no travel and no cost. We are working to present a minimum of one free webinar a week to keep members informed on the latest topics in healthcare. We are also working on the development of our annual 101 series to assist in training staff through a series of lunch-and-learn webinars on topics that members and nonmembers indicate as a need through a survey being sent out weekly in September.

The NJ HFMA education committee runs this program free of cost to the organization, members and non-members. We collaborate with organizations that have webinar platforms that can host the registration and webinar on behalf of the NJ HFMA. We have expanded our program to several organizations to provide a wide variety of topics. We are currently partnering with Alston and Bird, Baker Tilly, Besler, Deloitte, Fox Rothchild, Garfunkel Wild, and nThrive to name a few. If your organization would like to partner with us, you can visit our website and complete the webinar request form and email the form to hfmanj.webinars@gmail.com.

The NJ HFMA is nationally recognized for excellence in providing education. The organization’s goal is to meet the membership’s educational needs in a variety of forums with the webinar program being convenient and cost-effective. We understand that budgets are tight, but we all still need to stay on top of the ever-changing world of healthcare. Members can also spread the education by inviting colleagues to a conference room and viewing the webinar as a group. Just download the attendance form attached to the Free Webinar notice and follow the instructions on the form to ensure NJ HFMA can count everyone in attendance. If you have any recommendations for topics, possible partners or improvements, feel free to email hfmanj.webinars@gmail.com.
Recently, did you read an email two or three times to understand the message? If more than one person read that email, how many others had the same experience as you? Communication is effective only when the recipient understands the message.

Unclear messages create confusion and waste time. The Effective Written Business Communication session of the NJ HFMA Annual Institute will help you avoid sending unclear and confusing written messages – wasting other people’s time. The goal is for each attendee to leave with a better understanding of how to construct business writing that conveys his or her point clearly, succinctly, and professionally.

Healthcare administrators and financial administrators are in evolving roles - collaborating with clinical managers to create efficient and profitable service lines. We need to understand the clinical aspects and then communicate financial information clearly and succinctly. Communication skills have never been more important in our careers and in our organizations.

Attend the Effective Written Business Communication presentation on Wednesday, October 4th at noon and learn about:

- Using 30 seconds effectively
- Emulating Dr. Seuss
- Avoiding 5 mistakes that create the wrong impression
- Self-grading your written communication
- Advancing your career

Join us for the Effective Written Business Communication presentation; you will learn how to refine your written communication skills and have fun doing it. It will also change the way you read everything.

About the Author
Jim is president of Jim Grigsby Consulting, a revenue cycle and management consulting company. Grigsby is a national speaker, author of over 100 articles, and a Yerger Award winner for Florida HFMA’s Sunspots. Jim can be reached at jgrigsby@jimgrigsbyconsulting.com.

Please join Jim for his lunch & learn presentation, “Effective Written Business Communication” on Wednesday, October 4th at noon in Studio 1.
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In its FY 2016 Mid-Year Update and FY 2017 Work Plans, the OIG stated that the two-midnight hospital policy, “represents a change to the criteria that hospital physicians are expected to use when deciding whether to admit beneficiaries as inpatients or treat them as outpatients.” The OIG also stated that, “We will determine how hospitals’ use of outpatient and inpatient stays changed under Medicare’s Two-Midnight Rule by comparing claims for hospital stays in the year prior to and the year following the effective date of that rule. We will also determine the extent to which the use of outpatient and inpatient stays varied among hospitals.”

In its commentary, the OIG acknowledged two seismic issues:
1. There has been a “change to the criteria” used to evaluate Medicare inpatient and outpatient billing status; and
2. Comparisons will be made across providers and over time regarding adherence to two-midnight hospital policy requirements

Regarding issue #2, on December 19, 2016, the OIG published its first findings of hospital billing patterns since the Two-Midnight Rule change. As the title of the report implies, the OIG has discovered that, “Vulnerabilities Remain Under Medicare’s Two-Midnight Hospital Policy.”

In summary, the OIG determined that providers are, on average, variant from expected volumes on both short stay inpatient and long stay observation cases. What was not made clear in the OIG report is the reason why it believes such variances exist? The answer to this question likely rests within the details of issue #1 and how hospitals have adjusted (or not adjusted) to the use and application of “new criteria” in their daily and ongoing Medicare billing compliance processes.

Many hospitals continue to manage their Medicare billing status compliance through the legacy approach of having their case or utilization managers apply an inpatient level of care screening tool followed by physician review and medical necessity review of billing status for cases that fail to meet inpatient screening tool criteria. Although this process worked well prior to the two-midnight hospital policy criteria, today, it results in errors consistent with the rates of variance seen in the December 2016 OIG Report.

This legacy process is no longer applicable in the post two-midnight policy world for several reasons:
1. According to CMS guidance as provided in Reviewing Hospital Claims for Patient Status: Admissions On or After October 1, 2013, “It is not necessary for a beneficiary to meet an inpatient ‘level of care,’ as may be defined by a commercial screening tool, in order for Part A payment to be appropriate. In addition, meeting an inpatient ‘level of care,’ as may be defined by a commercial screening tool, does not make Part A payment appropriate in the absence of an expected length of stay of two or more midnights.”
2. According to CMS guidance as provided in Reviewing Short Stay Hospital Claims for Patient Status: Admissions On or After January 1, 2016, “Physicians need not include a separate attestation of the expected length of stay; rather, this information may be inferred from the physician’s standard medical documentation, such as his or her plan of care, treatment orders, and physician’s notes.”
3. In the FY 2016 OPPS, Section XV, “One commenter expressed concern that the proposed policy could create an opportunity for gaming by creating a market for independent parties to create and sell exception letters to hospitals that could be used to inappropriately document case-by-case exceptions to the Two-Midnight Rule.” In response, CMS commented, “We would expect such circumstances to be supported in the medical documentation, which would be subject to medical review.”

4. According to CMS 1599-F, the treating physician “is in a unique position to incorporate complete medical evidence in a beneficiary’s medical records, and has ample opportunity to explain in detail why the expectation of the need for care spanning at least two midnights was appropriate in the context of that beneficiary’s acute condition.”

Thus, the old process of criteria screen for level of care followed by a non-treating physician review of medical necessity based upon risk of an adverse outcome is no longer applicable. Rather, the two-midnight process requires that the treating physician’s order and documentation reflect the need for hospital services across two midnights, based upon reasonable standards of clinical care, in order for Medicare inpatient billing status to be considered appropriate. In addition, compliance efforts should be focused upon ensuring that treating physicians understand the two-midnight policy requirements and document appropriately in the chart to support the level of billing status requested by physician order. The compliance process should be internally self-audited on a regular and recurring basis and the process should not be focused solely on the transition of cases from observation to short stay inpatient status. Rather, all high-risk areas, as identified by CMS and the OIG, should be continually evaluated through a compliant process. Criteria screens and physician advisor reviews are tactics that alone do not beget compliance or revenue integrity --in fact, they often create non-compliance. Rather, case managers and physician advisors are but two components within a compliance and revenue integrity program that includes analysis of performance against key benchmarks, implementation of tactics focused on reducing non-compliant variance, and ongoing physician education, process remediation and iterative audit.

Thus, the OIG findings and the new regulatory guidance under the two-midnight hospital policy requires that hospitals pursue a top-to-bottom reassessment and redesign of their approach to Medicare billing compliance if that approach has not been assessed and modified post the two-midnight policy and/or continues to include the legacy pre-two-midnight policy tactics.

About the Author
Dr. Joseph D. Zebrowitz is Founder and Co-Chief Executive Officer of Versalus Health and has led the team in the development of an innovative approach to 2-Midnight rule compliance.

Join Dr. Zebrowitz for his presentation, “Two Midnight Rule Update: Why Your Organization is Still at Risk,” on Wednesday, October 4th at 10a.m. in Studio 1.

Footnotes

2CMS, “Reviewing Hospital Claims for Patient Status: Admissions On or After October 1, 2013” (03/12/14)
We face rapid change in healthcare today in virtually every aspect of our operations, from clinical delivery to increasing digitalization to dramatic shifts in patient populations to how we recruit, retain, and manage our workforce and even the manner in which our organizations are reimbursed for care. While change in our industry has become almost commonplace, the pace, complexity, and breadth of that change leads many of us to place a greater emphasis on the uncertainty of change rather than the potential benefits and opportunities that change creates.

In a 2006 study, Gneezy, List, and Wu observed “the uncertainty effect.” Many theoretical models of decision-making have generally built upon the principle that individuals make decisions based on their ability to assess and balance the value of all possible outcomes of a decision. Gneezy, et al, however, found that for many risky decisions, perhaps like those we face in healthcare today, the uncertainty effect leads decision-makers to value a risky outcome at a rate even lower than the worst possible outcome. In other words, the authors found that the uncertainty associated with risky decisions leads to an irrational risk avoidance. Organizations that avoid risky business options without considering whether the risk might be a prudent business decision that could lead to growth and success will not be able to keep pace. Although tolerance for risk varies significantly from individual to individual, this notion likely rings familiar for those of us with even a modicum of risk avoidance. The goal of enterprise risk management is to support decision makers by providing a level of confidence that the risks associated with a particular event or course of action can be managed competently and effectively by the organization. As an organization adopts an enterprise risk management process, it begins to address the management of risks and opportunities differently.

Enterprise Risk Management and Its Growth in Healthcare

Enterprise Risk Management (ERM) is a framework used by organizations to identify, analyze, and manage risks that threaten to undermine the organization’s ability to achieve its strategic objectives. ERM as a disciplined practice grew from the insurance industry’s development of risk management in the 1950s and spread to other financial services industries as a way to help manage market, credit, and other financial risks. Drawing from the principles of financial risk management for anticipating and measuring loss exposure, ERM has developed further as a tool to help organizations be more proactive in managing risks. Now, its application has spread to a variety of other industries, including both healthcare and higher education, to help leaders understand and plan for uncertainty and change. The American Society for Healthcare Risk Management theorizes that “ERM in healthcare promotes a comprehensive framework for making risk management decisions which maximize value protection and creation by managing risk and uncertainty and their connections to total value.”

Fall 2017
Although the conceptual framework utilized in ERM activities to evaluate the impact and likelihood that particular events might have on organizational health has been a part of risk assessment and management for as long as humans have grouped ourselves into organizations with defined goals and objectives, the discipline of ERM has matured and expanded in recent years to provide a clearer structure for how organizations identify and prioritize activities vital to ensuring their growth and relevance in the marketplace. The formal discipline of ERM emerged in the 1980s to provide a shared methodology for risk mitigation that spans industries, organizations, and functions.

Three predominant models for defining and applying ERM have emerged in the US: the Casualty Actuarial Society model, the Committee of Sponsoring Organizations of the Treadway Commission (COSO) framework, and the RIMS Risk Maturity Model. All share certain key elements, including aspects of detecting, avoiding, reducing, and transferring risks. In addition, all ERM models to varying degrees also help organizations define practices for identifying, analyzing, prioritizing, managing, and monitoring risks with respect to the organization’s strategic goals, regulatory requirements, operational effectiveness, financial performance and reputation.

Because of its applicability and utility in a wide range of organizational activities, the basic elements of the ERM framework have, over time, become increasingly integrated in a range of practices within healthcare organizations, even beyond strategic planning and assessment, including such core functions as internal audit, legal, compliance, quality, and claims risk management. Since passage of the Sarbanes-Oxley Act in 2002, the internal audit profession and many organizations applying the principles of Sarbanes-Oxley have adopted the COSO ERM framework (developed in 2004 as an extension of the COSO Internal Control framework). And given that functional unit leaders have been increasingly tasked in recent years to be more vigilant in anticipating and managing risks that affect their functional businesses, it can be challenging to illustrate the unique role that ERM brings as well as the critical importance that it has on the success of the business.

Another challenge faced by many organizations relates to prioritizing and categorizing risks in ways that help leaders, managers, and employees respond to identified risks. Risk categories or risk domains are generally utilized to group potential risks and opportunities for use in priority ranking. For healthcare entities, common risk domains include operational, clinical/patient safety, hazard, financial, human capital, strategic, legal/regulatory, compliance and technological risks and opportunities. On a deeper level, many organizations also struggle to differentiate between risks that can be managed at the functional level and those that cross functions to threaten enterprise-wide strategic and operational goals. In a 2013 Alert Bulletin, insurance provider CNA notes that, “The ERM model recognizes that today’s healthcare risks are complex and interconnected. For example, a violation of federal regulations in the life sciences arena may have an impact on various domains, including operational, strategic, financial, legal, and technological. By departing from the traditional view that exposures exist in separate silos, risk managers can analyze problems in greater depth and develop long-term, across the board solutions.”

Today’s turbulent change environment makes it more important than ever for organizations to develop the ability to understand and manage risks that cross the entire enterprise. Most of our organizations have implemented processes to assess and respond to functional risks that affect only a particular operating unit or business process. Now we must also develop the discipline to focus on the kinds of strategic and broad spectrum risks that operational and functional managers often assume that someone else will address, especially those risks that span multiple disciplines.

Specific issues that a health system might choose to evaluate include (1) the capability of the system to leverage newly available connectivity to national or global electronic health records, (2) the extent to which the health system is prepared for a weather event, financial disruption, or other threat, (3) whether the system maintains an appropriate mix of clinical disciplines and providers, (4) the impact of developments in technology and artificial intelligence on the system’s clinical operating model, and (5) whether the system has appropriate and available data, staff, and other resources to take advantage of available value-based purchasing and pay-for-performance reimbursement models. Some other enterprise risks to consider in the current environment include disruptive innovation in telemedicine, branding/name recognition particularly as part of clinical affiliations, recognizing and capitalizing on anticipated quality benefits post-merger, and being prepared for a host of healthcare reforms. Today, healthcare delivery organizations are not only focused on the provision of care but are also deeply involved in community health, housing, research and development, education, and with operating their own insurance practices. The ERM process within any organization should be designed to include all operations and activities of the organization so that success or failure of any business unit can be considered within the operational and strategic context of the entire organization.

**Leveraging Existing Strategic Practices to Develop an ERM Program**

When it comes to legal, compliance, and internal audit processes, it is not uncommon for organizational leadership to resist allocating necessary time, financial, and personnel resources to building an appropriate infrastructure. The same is often true for enterprise risk management, particularly given the relative inexperience that many healthcare leaders have with ERM. Part of this resistance comes from the challenge of...
understanding how ERM is distinct from and builds on existing risk identification and management activities.

Another challenge for leadership is appreciating that ERM is about more than risk identification and prevention; an effective ERM program also can help ensure that the organization is poised to keep current with – and perhaps be ahead of – the curve with respect to changes in the industry so that they can not only survive change but thrive during transitions. Drawing a parallel to the classic bestseller, Who Moved My Cheese, we imagine that the protagonist mice Sniff and Scurry adopted a rudimentary ERM framework that allowed them to anticipate the risk of depleting cheese supplies. Like Sniff and Scurry, organizations that constantly scan for risks and develop a plan for managing those risks in the future can thrive when the environment changes. This management fable also tells the story of Hem and Haw, successful individuals in one environment who became settled and stagnant and failed to anticipate the risks facing them in the future. Hem and Haw are much like organizations that are overly cautious about change because of the uncertainty effect. Like so many organizations in healthcare today, though, Haw adopts an ERM-like approach, initially taking little steps to test risks and develop a response and eventually taking advantage of bigger opportunities that become apparent through the discipline of risk identification, planning, and testing.

ERM is not a stagnant, one-and-done process. Although there is a clear benefit to creating and reviewing a formal risk inventory and list of opportunities at least annually, an organization that fully embraces ERM is constantly re-evaluating its risks and opportunities based on changes in its industry and environment. Some organizations tend to think of the risk register or inventory as the complete list of risks faced by the organization that must be addressed one-by-one until complete. We think of the ERM framework as providing a continuous roster of high priority issues that can lead us in new directions or that can keep us from achieving our goals.

A regular re-assessment of the risk environment allows us to work on developing mitigation strategies for a few high priority items at a time. As we develop a mitigation plan to help lower our assessment of the likelihood of a risk event or the adverse impact that the event could have on the organization, we remove that item from our high priority risk inventory and replace it with an item that was a little lower on our priority list, or perhaps with a new risk that emerged unexpectedly because of a change in the environment. In healthcare and academic medicine, we’ve all been surprised at different times by the passage of new legislation requiring significant changes to financial and operational strategies, by the vulnerabilities exposed during a natural or manmade disaster, by significant changes in the availability of certain types of providers or other workforce members, and by other events. Under an ERM framework, these are all examples of risks that could have been monitored for changes in trends, for which a strategy could have been developed to help us through that risk, and that might have indicated a ripe opportunity to capitalize on new business ideas or shifts in existing operating units. It is important to recognize that while some of these issues seem to have appeared out of nowhere, there have only been a few major changes in healthcare over the years for which an observant organization could not have prepared. An effective ERM program is intended to create a culture in which organizational leaders regularly scan the environment, think about the impact on the organization, and – like Sniff and Scurry – plan for both the worst and the best.

ERM programs can evolve from formalizing existing strategic work performed in clinical, financial and business units. Before attempting to apply an ERM methodology, we recommend that the organization perform an initial risk assessment, get staff familiar with ERM tools such as the heat map (Figure 2 in an example of one), and help them focus on understanding the strategic work currently going on in the organization. An essential element to making ERM work in an organization is bringing the key strategic leaders together to build consensus about the goals for the ERM framework. As part of this discussion, it is useful to help leaders understand that while the quantitative tools used in ERM lead to the perception that the scoring of the likelihood and impact of risks may seem objective, the ERM process in healthcare is really a subjective exercise. Risks and opportunities exist on a continuum of likelihood and impact.

To compound our challenge even further, in ERM we rarely have the benefit of empirical data or history on which to base our assessment of risk. As a result, we often end up assessing each risk through any number of personal or organizational lenses that bias the quasi-quantitative approach we take to ERM. As a result, we find that the best approach to prioritizing and managing enterprise risks recognizes that the assessment and prioritization of these risks must be considered in relationship to one another and with regard to their relevance to organizational success or failure rather than be thought of as an objective and absolute measure of risk.

Within a health system, leaders overseeing different types of healthcare delivery units such as long term care, physician practice, acute care, research, ancillary services, and insurance may each perform their own ERM analysis on a formal or informal basis. In developing or formalizing an ERM framework, it is important to consider the capabilities and roles of the leaders currently responsible for scanning the environment to ensure that the business remains viable and relevant. As part of implementing ERM, one might begin by identifying existing committee structures or workgroups at the management, leadership, or governance level and the extent to which they
have responsibility for (1) identifying, (2) evaluating, (3) prioritizing, and (4) addressing the risks and opportunities facing the organization. Within any organizational culture, the more one capitalizes on existing norms and structures, the easier it will be to implement new approaches and responsibilities.

The next step should be to analyze these existing meetings and structures to determine the extent to which they are appropriate for ERM practice. Given the important and potentially unfamiliar need to bring together knowledgeable thought leaders from a variety of areas — not necessarily just the VPs in charge — to be able to carefully identify and evaluate risks to the organization, it may become clear that existing structures may need to be substantially redesigned or that an entirely new structure needs to be implemented. Depending on the size and breadth of operations within the organization, some healthcare institutions choose to engage a professional whose sole responsibility is to partner with key leaders to drive, design, formalize, and maintain the ERM process. In smaller organizations or those with a more limited set of functions and services, existing personnel in compliance, internal audit, risk management, legal, finance, or other areas may be tasked with this organizing role. After engaging the key leaders who will best inform the ERM process, meetings of this ERM council should be scheduled at least quarterly to identify risks, conduct risk assessments, develop mitigation plans, monitor progress, and make needed updates as risks change. In larger or more complex organizations, it may be useful to develop subsidiary ERM committees that focus on a particular area (e.g., patient safety) or a single entity within a multi-entity health system to prioritize risks faced in that area and coordinate with the “parent” ERM council to manage risks throughout the organization.

One of the early responsibilities of the ERM committee should be to develop a risk register, or inventory of the key risks and opportunities. Although some organizations prefer to create a single, comprehensive inventory with dozens or sometimes hundreds of risks, we prefer to focus the committee on thinking through the 10 to 12 highest priority risks facing the organization. In our experience, the most effective approach has been for ERM personnel to talk with key leaders to develop an initial set of risks; then, bring the committee together to ensure a shared understanding of what is meant by the risk and its relationship to the organization. By facilitating a discussion of the right organizational leaders, the ERM team can create a manageable set of prioritized risks that can capture the attention and commitment of both the ERM committee and the individual(s) assigned to manage each risk. Regardless, the interdisciplinary ERM committee should be prepared to create a list of risks relevant to the institution. The figure below includes a list of potential risk concerns divided into different potential risk domains relevant to healthcare which might be used to initiate a conversation about risks facing an organization.

Once the ERM Committee agrees that a complete and relevant set of ERM risks and opportunities has been prepared, the risks and opportunities should be analyzed and scored. The goal of the scoring activity should be to prioritize the risks so that the organization allocates resources and efforts based on the relevance of the risk to the organization’s most important strategic objectives. There are many methods, scales and tools that can be used for risk ranking purposes. Whatever method is selected, one should take care to make sure that the approach is easy to understand, use, and update since the rankings should be revisited routinely.

Another critical component of the risk scoring process is the notion of risk tolerance or risk appetite. Organizations develop a tolerance for risk in much the same way as individuals. Organizations or business units focused on growth and innovation may be willing to accept a higher level of risk than those focused on maintaining market share and a particular brand identity. During the risk scoring process, it is important for the ERM committee to have frank discussions about the level of risk that the organization is willing to accept for each issue identified. While a number of quantitative approaches can be used to account for risk appetite in an ERM framework, one of the simplest to understand

<table>
<thead>
<tr>
<th>Potential Categories of Risk</th>
<th>Issues for Evaluation</th>
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<tr>
<td><strong>Strategic Considerations</strong></td>
<td>• Increased Competition</td>
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<td>• Clinical Research</td>
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<td>• Regulatory and Industry Environment</td>
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<td>• EHR Deployment</td>
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<td><strong>Reputational and Brand Considerations</strong></td>
<td>• Affiliations and Partnerships</td>
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<td>• Conflicts of Interest</td>
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<td>• Emergency Response and Incident Management Capability</td>
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<td>• Data Breach</td>
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<td>• Physical Plant</td>
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<td><strong>Operational Considerations</strong></td>
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<td>• Care Delivery</td>
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<td>• Deferred Maintenance</td>
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<td>• Payer Mix and Reimbursement Models</td>
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<td>• Data and Information Security</td>
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<td>• Employment Practices</td>
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*Figure 1: Table of Sample Healthcare Risks [continued on page 28]*
and implement is to incorporate risk tolerance into the impact score for each risk. For example, a risk-tolerant organization might give a lower impact score to an event for which it has greater tolerance. An alternate approach that will require a different type of documentation is to incorporate organizational risk appetite into the mitigation strategies developed to manage an identified risk.

For the purposes of illustration for presentations to leadership or governance and for analysis, risks can also be plotted using a scatter graph commonly referred to as an ERM heat map, as shown below in Figure 2. The heat map is useful for visualizing the relative impact and likelihood of each risk and is very helpful during the risk scoring process to stimulate thoughtful discussion among the ERM committee members. To help build consensus about risk priorities, it is useful to point out that risks that are “further up and to the right” on the heat map should be higher priority than other risks. When visualized this way, the heat map often prompts individuals to become more thoughtful about the potential impact that an event may have on the organization and to consider whether it may be more or less likely than certain other risk events discussed by the committee.

![Sample ERM Heat Map](image)

**Figure 2: Sample ERM Heat Map**

The Role of the Chief Compliance Officer, Chief Audit Executive, or Chief Risk Officer and C-Suite Executives with ERM

There are many ways that the organization’s chief audit executive, chief compliance officer, or chief risk officer can bring value to the ERM framework.¹⁰ They can partner with leadership¹¹ to provide analytical support and maintain the infrastructure for the ERM process, keeping leadership on track. Although it is not uncommon for legal, internal audit, or compliance to coordinate or facilitate the ERM process, the primary responsibility for identifying and analyzing risks and opportunities relevant to the organization and for prioritizing the ERM management activities for the organization must remain the responsibility of the entire leadership team and should incorporate significant input from the governance structure. The chief executive officer, president, or other leader of the management team primarily responsible for the strategic direction of the organization is in the best position to play a leadership role in the ERM process and to facilitate governance input and feedback on the ERM risk assessment process or mitigation plan.

For large and complex organizations that have the resources and ability to appoint a chief enterprise risk management officer, that individual should report to the chief executive and to the board of the organization. The chief ERM officer must also be resourced and positioned to ensure that risk mitigation activities are completed, monitored, and reported back for evaluation purposes. For other organizations, the chief executive officer, chief administrative officer, or another strategic leader often serves as the chair for the ERM Committee meetings.

It also falls to the chief ERM officer to consider the culture and environment of the organization to ensure that the style and mode of ERM activities align with organizational approaches. For example, a flat organization with respect to responsibilities and governance will chafe at the notion of a highly hierarchical ERM approach with a chief ERM officer who barks commands to department chairs and other personnel. Conversely, a loose, more collaborative ERM committee structure and approach will be perceived as inefficient and wasteful in a top-down, command-and-control organization. It is essential that the organization appoint an ERM leader and develop an ERM structure consistent with its own organizational identity, even when the ERM framework is being set up in the aftermath of an adverse event. Although it may seem appropriate to establish a highly centralized ERM approach in the wake of a serious event, a decentralized organization will resist the structure, rendering the ERM framework meaningless.
All senior leaders in an organization play a vital role in ERM. Each, including the chief medical officer, chief operations officer, chief financial officer, chief nursing officer, and other members of the senior team, has unique, topical subject matter knowledge regarding current trends and impactful changes in her respective field. It is critical that all senior leaders keep abreast of changes in the industry and bring forward any proposed strategic changes to the ERM committee. Day-to-day changes affecting one’s functional responsibilities can have a significant impact on the need for or the implementation of a mitigation plan. For example, if there is a new payment model being utilized by many of the organization’s payors or if legislation changes reimbursement methodology for governmental payors, the chief financial officer should think through the likelihood and impact of this change on the organization to determine the extent to which the organization should analyze the impact and develop or modify the appropriate risk mitigation plan. If the chief operations officer successfully secures unanticipated grant funding for needed physical plant updates, he should consider the appropriateness of closing the related item or removing it from the mitigation plan completely due to changed circumstances and priorities.

Conclusion

Enterprise risk management frameworks for healthcare organizations have become an essential tool for navigating the complex changes occurring in our industry. ERM can help focus key leaders on a small set of high priority issues that have the potential either to help the organization capitalize on new opportunities or to threaten the organization’s ability to achieve its goals. When implemented well, ERM also has the potential to increase risk awareness throughout the organization, helping individuals think beyond their functional silos to see the impact of various events on the entire organization. By aligning individual thinking with organizational objectives, ERM helps the organization be proactive and strategic, focusing not on what the organization can’t do, but on what it must to remain a leader.

About the Authors

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Footnotes

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<td>Joseph Zebrowitz</td>
<td>Versalus Health</td>
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<td>John Fundingsland, Ken Poray</td>
<td>Hexaware Healthcare Technologies</td>
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<td>ECG Management Consultants</td>
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<tr>
<td>Studio 4</td>
<td>Outcomes/Lessons Learned from the CMS Joint Replacement Bundled Payment Initiative</td>
<td>Donna Cameron</td>
<td>Navigant Consulting, Inc.</td>
</tr>
<tr>
<td>Boardroom</td>
<td>Clinical Validation What Does It Mean?</td>
<td>Laura Leg</td>
<td>Healthcare Resource Group</td>
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<tr>
<td>10:50 AM - 11:00 AM</td>
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<tr>
<td>Studio 1</td>
<td>Understanding Physician Contracting to Reduce the Risk of Fraud and Abuse</td>
<td>Jennifer Shimek, Matthew Colford</td>
<td>KPMG LLP</td>
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<tr>
<td>Studio 2</td>
<td>MACRA: Threats and Opportunities - An Introduction to MIPS and APMs</td>
<td>Idette Elizondo, John Harris</td>
<td>Veralent</td>
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<tr>
<td>Studio 3</td>
<td>Accounting &amp; Auditing Update</td>
<td>Lou Feuerstein, Crispin Hildebrand</td>
<td>Grant Thornton LLP</td>
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<td>Studio 4</td>
<td>Outsourcing Healthcare Services and the Integrity of Data</td>
<td>Karen Henderson, Anupam Goradia</td>
<td>WithumSmith+Brown</td>
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<td>Boardroom</td>
<td>Compensation Valuation: The Importance of Fair Market Value Assessments</td>
<td>Monica Kaden</td>
<td>Marks Paneth LLP</td>
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<td>11:50 AM - 1:00 PM</td>
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<tr>
<td>Vendor Hall</td>
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<tr>
<td>12:00 PM - 12:30 PM</td>
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<td>12:30 PM - 1:05 PM</td>
<td><strong>Lunch and Learn</strong></td>
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<td>Studio 1</td>
<td>Effective Written Business Communication</td>
<td>Jim Grigsby</td>
<td>Jim Grigsby Consulting</td>
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<tr>
<td>Ballroom</td>
<td>Welcome and intros with Scott &amp; Mike</td>
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<tr>
<td>1:15 PM - 2:30 PM</td>
<td><strong>Keynote</strong></td>
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<tr>
<td>Ballroom</td>
<td>Charity Event Speaker Keynote</td>
<td>Ilise Zimmerman</td>
<td>Partnership for Maternal and Child Health of Northern NJ</td>
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<tr>
<td>2:30 PM - 3:00 PM</td>
<td><strong>Break with Vendors</strong></td>
<td></td>
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<tr>
<td>3:00 PM - 3:50 PM</td>
<td><strong>Breakout Sessions</strong></td>
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<tr>
<td>Studio 1</td>
<td>Hot Topics In Compliance</td>
<td>Robert Bacon</td>
<td>University of Pennsylvania Health System</td>
</tr>
<tr>
<td>Studio 2</td>
<td>Medicare Regulations that Revenue Cycle Needs to Know</td>
<td>Ronald Hirsch</td>
<td>R1 Physician Advisory Services</td>
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<td>Studio 3</td>
<td>Healthcare Industry Tax Update &amp; President Trump's 2017 Tax Reform</td>
<td>Hayley Shulman, Linda Gnesin</td>
<td>WithumSmith+Brown, PC</td>
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<tr>
<td>Studio 4</td>
<td>Data Isn't Boring, We Swear!</td>
<td>Tracy Davison-DiCanto, Travis Hunt</td>
<td>Princeton HealthCare System</td>
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<td>Boardroom</td>
<td>Wage Index: New and Improved?</td>
<td>Scott Besler</td>
<td>Besler Consulting</td>
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<td>3:50 PM - 4:00 PM</td>
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<td>4:00 PM - 4:50 PM</td>
<td><strong>Breakout Sessions</strong></td>
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<td>Studio 2</td>
<td>Charity Care and Community Benefit Reporting on Schedule H</td>
<td>Nicole Sokolowski, Justin Lowe</td>
<td>EY</td>
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<tr>
<td>Studio 3</td>
<td>Making Care Affordable Without Sacrificing Financial Performance</td>
<td>April York</td>
<td>Novant Health</td>
</tr>
<tr>
<td>Studio 4</td>
<td>The Journey Toward Risk - What’s Required and What Could Go Wrong?</td>
<td>Michael Ruiz de Somocurcio</td>
<td>Regional Cancer Care Associates</td>
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<tr>
<td>Boardroom</td>
<td>Using Data to Define Your Post-Acute Strategy</td>
<td>Marc Zimmet, Vincent Fedele</td>
<td>Zimmet Healthcare Services Group, LLC</td>
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<td>Charity Event Benefiting Partnership for Maternal &amp; Child Health of Northern NJ, the Central Jersey Family Health Consortium and the Southern New Jersey Perinatal Cooperative</td>
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## Thursday, October 5, 2017

<table>
<thead>
<tr>
<th>Time</th>
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<tbody>
<tr>
<td>8:45 AM - 9:00 AM</td>
<td>Awards Ceremony</td>
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<tr>
<td>Ballroom</td>
<td>NJ HFMA Chapter Awards Ceremony</td>
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<tr>
<td>9:00 AM - 9:50 AM</td>
<td>General Session</td>
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<tr>
<td>Ballroom</td>
<td>2017 Healthcare Regulatory Update</td>
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<tr>
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<td>Michael McLafferty, EisnerAmper LLP</td>
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<tr>
<td>9:50 AM - 11:05 AM</td>
<td>Keynote Address</td>
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<tr>
<td>Ballroom</td>
<td>Keynote Speaker: Captain Al Fuentes, FDNY - 9/11 First Responder</td>
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<td>Break with Vendors</td>
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<tr>
<td>11:30 AM - 12:20 PM</td>
<td>General Session</td>
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<tr>
<td>Ballroom</td>
<td>Healthcare Reform: Where Do We Go From Here?</td>
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<td>12:20 PM - 1:40 PM</td>
<td>Lunch</td>
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<td>Vendor Hall</td>
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<tr>
<td>12:30 PM - 1:00 PM</td>
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<td>Vendor Demo</td>
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<tr>
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<td>Vendor Demo</td>
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<td>12:30 PM - 1:20 PM</td>
<td>Lunch and Learn</td>
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<tr>
<td>Studio 1</td>
<td>Keeping Up with Social Media Trends &amp; Practical Applications for Career Development</td>
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<td>Matt Basilo, Rhonda Maraziti, WithumSmith+Brown, PC</td>
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<td>Vendor Demo</td>
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<tr>
<td>1:40 PM - 2:30 PM</td>
<td>Breakout Sessions</td>
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<tr>
<td>Studio 1</td>
<td>Mission Critical: Managing and Protecting Digital Patient Identities</td>
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<td>Ken Halaby, Experian Health</td>
</tr>
<tr>
<td>Studio 2</td>
<td>How Penn Medicine’s Finance and Revenue Cycle Teams Joined Forces with</td>
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<tr>
<td></td>
<td>Their Banking Partner to Streamline Monthly Reconciliation</td>
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<tr>
<td></td>
<td>Eileen Murray, Frederick Bloesch, Erika Treacy, Margaret Dowling</td>
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<tr>
<td>Studio 3</td>
<td>Measuring Improved Efficiency Due to Hospital Mergers</td>
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<td>Studio 4</td>
<td>Alternative Payment Model: Medicare BPCI Bundle Payment and its</td>
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<td>Financial and Clinical Impact</td>
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<td>Kate Gillespie, Christine Gordon, Virtua</td>
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<tr>
<td>Boardroom</td>
<td>The Key to Patient Satisfaction and Financial Improvement</td>
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<td>Maria Facciponti, FHFM, nThrive</td>
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<td>2:30 PM - 3:00 PM</td>
<td>Break with Vendors</td>
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<tr>
<td>3:00 PM - 3:50 PM</td>
<td>Breakout Sessions</td>
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<td>Studio 1</td>
<td>Evaluating Your Compliance Program for Best Practice</td>
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<td>Bret Bissey, MediTract</td>
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<td>Studio 2</td>
<td>Strategies to Help Patients Deal with Financial Toxicity</td>
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<td>BreAnn Meadows, PATHS, LLC</td>
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<td>Studio 3</td>
<td>Bridging the Gap: Understanding the Role of Enterprise Risk Management</td>
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<td>During Healthcare Change</td>
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<td>Danette Slevinski, Tim Fournier, University Hospital</td>
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<tr>
<td>Studio 4</td>
<td>Accountable Care Organizations: Performance and Progress</td>
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<td>David Gregory, Baker Tilly</td>
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<tr>
<td>Boardroom</td>
<td>Innovations in Primary Care Delivery: Beyond the Patient Centered</td>
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<td>Medical Home</td>
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<td>Robert Hill, Veralon</td>
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<tr>
<td>4:00 PM - 4:50 PM</td>
<td>General Session</td>
</tr>
<tr>
<td>Ballroom</td>
<td>The Alliance Effect</td>
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<tr>
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<td>Dr. Cortney Baker, Baker Management Group</td>
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<tr>
<td>6:00 PM - 8:00 PM</td>
<td>President’s Reception</td>
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<td>Borgata Central Conference Center</td>
<td>President’s Reception</td>
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<tr>
<td>10:00 PM - 11:30 PM</td>
<td>Late Night Event Featuring Jimmy and the Parrots</td>
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<td>Late Night Event Premier Nightclub</td>
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## Friday, October 6, 2017

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<tr>
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<tbody>
<tr>
<td>9:00 AM - 10:15 AM</td>
<td>Keynote Address</td>
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<tr>
<td>Ballroom</td>
<td>Mastering Your Memory</td>
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<td>Tyler Enslin, Direct Development Training</td>
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<tr>
<td>10:15 AM - 10:25 AM</td>
<td>Transition Break</td>
</tr>
<tr>
<td>10:25 AM - 11:40 AM</td>
<td>Panel Discussion</td>
</tr>
<tr>
<td>Ballroom</td>
<td>C-Suite Panel Discussion</td>
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<td>Gui Valladares, MBA, Chief Financial Officer, Princeton HealthCare</td>
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<td></td>
<td>System / Jeffrey LeBenger MD, Chairman &amp; CEO Summit Medical Group,</td>
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<td>Summit Health Management / Theresa Larivee, Chief Executive Officer,</td>
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<tr>
<td></td>
<td>Pennsylvania Hospital / Anthony J. Mazzarelli, MD, JD, MBE, Chief</td>
</tr>
<tr>
<td></td>
<td>Physician Executive, Cooper University Health Care</td>
</tr>
<tr>
<td>11:40 AM - 12:30 PM</td>
<td>General Session</td>
</tr>
<tr>
<td>Ballroom</td>
<td>The Power of Analytics: Ideas to Improve Performance</td>
</tr>
<tr>
<td></td>
<td>Asha Saxena, FTI</td>
</tr>
</tbody>
</table>
Change is a predominant force in healthcare and not only must healthcare organizations plan for shifts resulting from administration changes, they must also navigate the dynamic landscape of new and evolving payment models and mechanisms for capturing and billing for services – such as with the implementation of ICD-10-CM (ICD-10). For healthcare executives, and the lawyers and consultants who assist them, the big questions are how will these changes in personnel affect fraud and abuse enforcement by the federal government, and more broadly, how within this regulatory environment can they successfully adjust to the new payment models and reimbursement mechanisms. As we describe below, it would appear that, based on recent events, most, if not all of the trends that began in the Obama administration and earlier will continue.

Healthcare Enforcement Will Continue to be a Priority

Although there has been some speculation that Attorney General Sessions would shift resources from healthcare fraud to violent crime and other initiatives, this seems to be belied by government statements and actions. Multiple high-level government officials at DOJ have stated since President Trump’s election that healthcare fraud enforcement is and will remain a priority for DOJ. Similarly, if for no other reason than that healthcare fraud is a rich source of revenue for the government via fines, penalties and forfeitures, DOJ continues to commit significant resources to healthcare fraud enforcement. This has been reflected in the establishment of yet more healthcare fraud units and the recent “takedown” of 412 individuals in what was described as the largest healthcare fraud enforcement action in history.

The DOJ Will Continue to Press Individual Liability

Under the Obama Administration, DOJ promulgated the so-called “Yates Memorandum,” which emphasized the prosecution of individuals for corporate wrongdoing. Perhaps most significant about the memorandum was its requirement that an organization must disclose all information about individual misconduct to receive cooperation credit and that DOJ would pursue civil litigation against individuals irrespective of their ability to pay a judgment. That DOJ intended to follow through on this policy with respect to healthcare executives was reflected in its $1 million settlement with the CEO of Tuomey Healthcare System, separate and apart from the government’s $72.4 million settlement with the hospital, and its $1 million and $500,000 settlements with executives of North American Health Care, Inc., separate and apart from the company’s $28.5 million settlement.

There has been no indication that DOJ under AG Sessions will back away from the policy of aggressively pursuing individuals both criminally and civilly for healthcare fraud and abuse. Indeed, in a May 10, 2017 Memorandum, AG Sessions directed all DOJ prosecutors to “charge and pursue the most serious, readily provable offense” in all criminal matters. Although aimed at narcotics and violent offenses, the memorandum appears to apply to fraud actions, including healthcare matters.
Compliance Programs Will Continue to be Important and Subject to Government Scrutiny

The effectiveness of the compliance programs of healthcare providers will continue to be an important element of the government’s assessment of whether or not to initiate an enforcement proceeding and the types of penalties to seek. In recent months, significant guidance has become available to guide healthcare providers. DOJ’s Criminal Division in March of 2017 released guidance entitled Evaluation of Corporate Compliance Programs. Even more detailed guidance specific to healthcare was released in March 2017 in a joint effort of the Health Care Compliance Association and HHS-OIG (the “OIG Compliance Effectiveness Guidance”). The OIG Compliance Effectiveness Guidance provides a detailed template to evaluate all the elements of a healthcare compliance program.

In November of 2015, DOJ hired Hui Chen as a “full-time compliance expert.” As a former compliance counsel and federal prosecutor, her role was to evaluate organization compliance programs as part of DOJ’s process for resolving fraud investigations. Although Ms. Chen recently resigned from DOJ, there is every indication that DOJ will continue to look to the effectiveness of compliance programs in negotiating resolutions of healthcare investigations. Indeed, DOJ is actively seeking a replacement for Ms. Chen.

The Implementation of ICD-10 Presents Greater Compliance Challenges for Providers

Within a regulatory environment consistently focused on identifying and combatting fraud, healthcare providers must now also navigate much greater complexity and specificity in medical claim coding and documentation with the implementation of ICD-10. The federal government has made it abundantly clear in recent enforcement cases that instances of “upcoding” and/or an underlying failure to support medical necessity in the medical record can lead to liability. For example, on June 2, 2017, Fredericksburg Hospitalist Group, P.C. and 14 of its member shareholders agreed to pay approximately $4.2 million to the government to settle allegations of False Claims Act violations based on alleged upcoding of evaluation and management (E&M) codes in connection with the provision of hospitalist services to patients.

It is widely recognized throughout the industry that many providers were ill prepared for the drastic documentation changes required under ICD-10 with regards to, among other things, coding sequence of patient encounters, coding laterality, compliance of patient treatments and external cause codes. Even where providers are not engaged in actual fraud, there remains significant audit risk where providers have not caught up with these coding rule changes. Simply put, the inability to properly code services can lead to regulatory scrutiny, even if no fraud exists. The fact that the government is intent on ferreting out fraud increases the likelihood of regulatory audits of provider medical documentation and coding practices. Therefore, compliance leaders and financial executives alike must ensure proper training and systems are in place within their organizations to account for the many existing ICD-10 changes as well as new changes and adjustments which are constantly on the horizon. For example, for 2018 there will be 360 new codes, 142 deleted codes and 226 revised codes. These 2018 ICD-10-CM codes are to be used for discharges occurring from October 1, 2017 through September 30, 2018 and for patient encounters occurring from October 1, 2017 through September 30, 2018.

Failure to update and utilize correct codes not only can result in regulatory scrutiny and potential liability but also claims denials and/or delayed claims processing, thereby impacting revenue and cash flow. Furthermore, as our healthcare system continues with reform through programs such as PQRS, MACRA, MIPS and other quality assurance programs, services will be reimbursed much like the inpatient hospital claims that are based on diagnosis related groups (“DRG’s”). A hallmark of such programs is that they are monitored and regulated based on the levels of specificity for the severity of a patient’s presenting problem. Thus, as these payment systems continue to evolve, it will become even more important for provider documentation and coding to be at a higher level of specificity and in conformance with the ICD-10 rules.

Tips on Mitigating Risks in This Regulated and Complex Environment:

Given the current healthcare climate, it is evident that providers must engage in certain best practices in order to ensure compliance, mitigate risks, and put their organizations in the best position to capture revenue for legitimate, medically-necessary services performed. Here are some best practice tips that finance and compliance executives should consider to achieve these goals:

1. Finance, Compliance Departments and Executives Must Collaborate: All too often compliance departments work in isolation, separate and apart from finance departments within healthcare organizations. We suggest having a strong collaboration between compliance and finance, especially on issues impacting government repayments and other hot button compliance issues. Standing meetings to facilitate ongoing communications tend to be a good starting point.

2. Have A Consistent Auditing and Monitoring Plan: Through its 1998 Compliance Program Guidance for Hospitals and its 2005 Supplemental Compliance Program Guidance for Hospitals, the OIG made it clear that auditing and monitoring are critical elements of an effective compliance program. The OIG Compliance Effectiveness Guidance sets forth ideas on auditing and monitoring compliance program elements, such as periodically reviewing educational/training materials and policies and procedures to ensure that they are continued on page 34
up-to-date, understandable to staff and accurately reflect the organization’s actual business processes. Finance and compliance departments can use this document to identify those particular elements that may be most applicable to their individual organizations, as they work on developing specific auditing and monitoring policies and procedures and the overall structure of their compliance programs.

3. **Continue to Educate your Board:** It is not news that it remains vital for boards to be apprised of the current healthcare regulations and government actions, as well as their roles and responsibilities, and now under Yates, the personal liability healthcare executives and Board members share. It is imperative for compliance and finance executives to continue to update and educate their boards in these areas.

4. **Update your Annual Risk Assessment and Make Sure the Process Works:** Now, more than ever, with the publication of the OIG Compliance Plan Effectiveness Guidance, organizations must have current risk assessments based on a comprehensive and functioning process for identifying and addressing company risks. There is no “one size fits all” solution to how the risk assessment process is resourced within a healthcare company. Often the risk assessment process falls to some combination of the compliance, finance, and internal audit functions. The important factor is not what department leads the risk assessment process, but that the process exists and that the appropriate departments and individuals within the organization are a part of the process and the implementation of any corrective actions.

**Conclusion**

It is safe to say that, even with major federal administration changes, identifying and curtailing healthcare fraud and abuse remains a major focus of federal government regulators. The returns on such activities continue to provide a strong incentive. Within such a regulatory environment, and with ever-growing complexities in medical coding and billing and evolutions of new payment models, healthcare finance and compliance executives must remain focused on finding ways to address operational, compliance and financial complexities to ensure their organizations remain compliant and financially successful.

**About the Authors**

Robert Senska is the General Counsel/Director of LW Consulting, Inc., a healthcare consulting firm. Rob can be reached at RSenska@LW-Consult.com.

Jack Wenik is a partner at the law firm of Epstein, Becker & Green in its healthcare and life sciences group. Jack can be reached at JWenik@ebglaw.com.


**Footnotes**


2See, e.g., April 20, 2017 Remarks of Acting Principal Assistant Attorney General Trevor N. McFadden (commenting that “hospitals and healthcare companies around the country … and their management will be held accountable for fraudulent misconduct.”), available at https://www.justice.gov/opa/speech/acting-principal-deputy-assistant-attorney-general-trevor-n-mcfadden-justice-department-s.

3May 18, 2017 Remarks of Acting Assistant Attorney General Kenneth A. Blanco (commenting that he spoke to AG Sessions and that “The investigation and prosecution of healthcare fraud will continue; the department will be vigorous in its pursuit of those who violate the law in this area.”); available at https://www.justice.gov/opa/acting-assistant-attorney-general-kenneth-blanco-criminal-division-speaks-american-bar.


8The guidance document is available at https://www.justice.gov/criminal-fraud/page/file/937501/download.


Know Your Roots.

As the nation’s premiere provider of financial, operational, and clinical consulting services, McBee gets to the root cause to help providers understand where issues derive and track any patterns to arm providers with the right insights to develop a sustainable and effective plan to address them.
Most PFS directors are familiar with productivity benchmarks, which generally suggest something between 40 and 60 follow up touches per day for follow up staff. Although these benchmarks can highlight when staff are falling below those standards, they fail to help improve outcomes in three fundamental ways:

1) They don’t give staff (or managers) any insight on how to reach the benchmark
2) They don’t speak to the likelihood of collection on the accounts that staff are working
3) They don’t measure the quality of the actions performed by the staff when they do touch an account.

By deploying some analytical horsepower to their AR before accounts get assigned, hospital revenue cycle managers can improve productivity, present the right claims to their follow up staff, and maximize follow up quality in order to realize the highest return on the labor cost related to follow up. The result is lower absolute levels of AR, “cleaner” AR where the true value is easier to evaluate, and ultimately more cash collections.

Pulling the Right Levers

To understand the levers that can improve follow up performance, it is first valuable to think about the goals of follow up and some of the building blocks that make up a successful PFS operation.

The goal of any PFS operation is simple enough -- maximize collections, while minimizing cost-to-collect. But too often, managers assume that those outcomes and costs are nearly fixed -- that improvements will not fundamentally change results. As a result, they seek incremental, marginal changes in the thought process. But breaking down the components of follow up brings radical, step function process improvements into focus.

For example, our research indicates that roughly 40% of total AR volume at an average provider has no cash value. It is made up of inappropriately posted contractuals, claims that have passed filing or appeal limits, or denials like bundling which will not be paid. Although the posting process is intended to adjust many of these balances to zero, complexities with payer remits, takebacks, and inconsistent use of denials codes leave these balances open. Improvement in the posting process can reduce the frequency of these issues, but is unlikely to remove them altogether.

Another large segment of claims in most provider AR -- roughly 25% -- has a collection opportunity, but requires only a very simple action. For example, posting issues or partial denials can mean that claims stay in the primary financial class even after payment is complete. The simple step of moving the balance to the next payer or to the patient can start the payment process. Another common problem comes when a claim bills out of the patient accounting system, but never reaches the payer, failing in the bill editor, the clearinghouse, or even within the payer adjudication system. Resolving the failure or even simply rebilling the claim is usually enough to get the claim on the path to payment.

But in a common PFS shop, a claim in either of these categories will require staff time to resolve. Each time one of these claims shows up on a worklist, staff need to spend time researching the claim -- understanding the billing and follow up history, determining why it hasn't paid, and evaluating potential next steps. Only when that process is complete can staff actually start working the claim, creating value by either collecting on or adjusting the balance. Given a generally accepted average of approximately 10 minutes to work a claim, staff are likely to use 6-8 minutes of that time in the research phase and only 2-4 taking
the actual steps that create value. That means at least 60% of the time, staff activity is not directly adding value.

**Where Staff Create Value**

Whether the claim has a collection opportunity or not, and whether staff spend 10 minutes or 2 minutes actually creating value, that effort counts towards productivity. If 60% of staff time is research and not action, and if at least 40% of claims have no value and action and another 25% have minimal value, it means only 14% of the actions taken by follow up staff provide substantial value.

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<tr>
<th>Type of Account</th>
<th>Time Allocation</th>
<th>Action</th>
<th>Research</th>
</tr>
</thead>
<tbody>
<tr>
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<td>40%</td>
<td>16.00%</td>
<td>24.00%</td>
</tr>
<tr>
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<td>10.00%</td>
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<tr>
<td>Complex Claims</td>
<td>35%</td>
<td>14.00%</td>
<td>21.00%</td>
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</tbody>
</table>

In order to improve outcomes and generate more cash at lower costs, PFS shops should seek approaches that focus staff time on the High Value category and de-emphasize the No and Low Value categories. In fact, most managers and more workflow tools have adopted this approach already. Organizing work queues by balance and age is an effort to achieve this goal, but it only provides the most basic benefits.

An advanced, more robust version of that effort would shift staff time away from the non-collectable and simple claims to put more focus on those with real collection opportunities.

The goal of those analytics should be to 1) route the right claims to staff to be worked, and; 2) help staff work them in the most efficient and efficacious manner possible.

Using analytics, we have seen clients segment their AR into four distinct categories:

1) Non-Collectable
2) Simple Claims
3) Analytics Suggestions
4) Complex Claims

First, the analytics identify claims with no collection opportunity. Using automation, these claims are adjusted off to the appropriate write-off or contractual codes. The use of automation eliminates almost all staff time previously devoted to this simple administrative task.

Similarly, where analytics indicate a simple task (like rebilling or changing a financial class) is the appropriate next step in the collection process, automation can take those actions. In Non-Collectable and Simple Claims, automation can eliminate 65% of the effort required of follow up staff.

The third and fourth categories are subsets of the complex claim categories. Advanced analytics can be used to determine the appropriate next steps and offer analytically driven suggestions. Our experience with clients demonstrates this correlates to roughly 25% of claims. By providing analytic insight into the reasons for non-payment, this process allows staff to minimize the time they spend researching a claim and move rapidly to the action phase. Our experience indicates that the use of advanced analytics can focus up to 80% of staff time on actions as opposed to research. These analytics can also improve staff productivity by grouping accounts with similar next steps and thereby allowing staff to move quickly through claims with similar problems and solutions.

Unfortunately, in 10% of cases, the analytics cannot provide any additional insight and staff are forced to work those Complex Claims in the same manual process as before, devoting a majority of time to research.

### 400% Improvement in Follow Up

By eliminating staff time spent on claims that can be automated and minimizing the research component on the remaining claims, use of analytics can shift the time allocation

<table>
<thead>
<tr>
<th>Type of Action</th>
<th>Type of Account</th>
<th>Volume</th>
<th>Time Allocation</th>
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<tr>
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<td>Non-Collectible</td>
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<td>0.00%</td>
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<tr>
<td>Automated</td>
<td>Simple Claims</td>
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<td>0.00%</td>
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<tr>
<td>Manual</td>
<td>Analytic Suggestions</td>
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<td>71%</td>
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<td>14.30%</td>
</tr>
<tr>
<td>Manual</td>
<td>Complex Claims</td>
<td>10%</td>
<td>29%</td>
<td>11.40%</td>
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</tr>
<tr>
<td>Low Value</td>
<td>68.60%</td>
<td></td>
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</table>

continued on page 38
of staff from only 14% high value time to nearly 70% high
value time, more than quadrupling their efforts!

By eliminating the low value touches and providing an
intelligent work queueing process, advanced analytics can
provide a roadmap for managers and staff attempting to
reach benchmark productivity standards. Analytics can also
make those touches more valuable by making sure that staff
time is focused on claims with real collection opportunities.
And whether through automation or analytical suggestions,
managers who deploy advanced analytics can improve the
quality of staff time by ensuring consistency and standardization
of outcomes. Each of these improvements will contribute to
more cash and lower AR days, allowing providers to meet or
even exceed their own operational benchmarks.

Please join Colburn Hill Group for a discussion of our
solution in Boardroom One at 1:05p.m., October 5th at the
NJ/Metro Philly HFMA Institute in Atlantic City.

About the Authors
Peter Angerhofer is a principal with Colburn Hill Group. Prior
to forming Colburn Hill, Peter spent 10 years at Accretive Health
(having started as part of the pre-revenue development team) and
had worked for Deloitte Consulting and CSC/APM, as well as
serving in health policy roles on Capitol Hill. Peter can be reached
at pangerbo@colburnhill.com.

Jeff Means is a principal with Colburn Hill Group. Jeff has also
spent 10 years with Accretive Health, before which he had served as
a Captain in the United States Army; he is an Operation Enduring
Freedom veteran. Jeff can be reached at jmeans@colburnhill.com.

Thinking about personal and professional growth, recognition and advancement?
Look no further - become “Certified Healthcare Financial Professional!”

For the first time ever at the Institute, NJ HFMA is
organizing FREE on-site CHFP certification study review and
tax sessions!

The Certified Healthcare Financial Professional (CHFP)
program has been recently updated to provide the wide range
of business and financial skills required for understanding the
new financial realities of ever-changing healthcare industry: a
shift from volume to value in care and payment models, a focus
on population health and patient outcomes, price transparency,
increased cost-sharing, and consumerism.

The review session will connect the CHFP study guide
concepts to practical applications in order to help you prepare
for the CHFP exam. Taught by subject matter experts, this
course will utilize high-level, real-world examples, giving you
the opportunity to ask questions and hone your knowledge.

Join us on October 4th and October 5th at NJ/Philly
HFMA 41st Annual Institute for training and testing:
• Wednesday, October 4th: 9 a.m. – 1 p.m.
  Group on-site study review session for Module I
• Wednesday, October 4th: 3 p.m. – 5 p.m.
  Module I exam
• Thursday, October 5th: 1:30 p.m. – 5 p.m.
  Module II exam

Certification review sessions are free, but participants are
required to register for Module I exam and to read the six
chapter study materials PRIOR to the sessions. Module I
materials are available at a group discount rate of $320
and there is no additional charge for the exam. Module II is only
available upon successful completion of Module I. The cost of
the Module II exam is $300.

Participants should bring their own laptops for reviewing
materials and taking the exam. A wireless internet connection
will be available to all participants.

Upon completion of both Modules, the New Jersey or
Philadelphia HFMA chapters will reimburse the cost of
your certification in full!

To attend the certification study review and exam sessions,
participants must first register for the Annual Institute. Please
click here for registration for the Annual Institute: https://
www.regonline.com/builder/site/?eventid=1996829.

To register for Module I CHFP materials, study review and
exam sessions, please see our homepage, http://hfma.org.

For any other information please contact Amina Razanica,
MBA, CHFP, at arazanica@njha.com or at 609-275-4029.
At Novant Health, we are on track to becoming a multi-state, super-regional health system. Headquartered in Winston-Salem, N.C., Novant Health is amassing market share via strategic alliances, shared services and acquisitions. We now have 530 locations, including 15 medical centers and 480 outpatient sites throughout Virginia, Georgia and the Carolinas.

As part of Novant Health’s six-point strategy instituted a few years ago, we reviewed service lines and pricing with the goal of offering responsive products, pricing and partnerships that anticipate the needs of patients and the community. The health system devised a complementary ambulatory strategy that includes extended service hours for patient convenience and redirect patients to more affordable care settings than urgent/emergency care. Our satellite acute care facilities cover 75% to 80% of procedures that can be handled in an outpatient setting.

Novant Health has responded to the consumer aspect of healthcare by changing the look and feel of billing statements, introducing new ways for patients to pay their portion of care, and presenting payment options in a way that is easily understood. We understand patients are consumers who have a voice and choice in their healthcare. The changes we’ve made have all been with the patient in mind. If the patient can say, “This bill is easy for me to understand,” then we’ve achieved our goal.

Novant Health has responded to the consumer aspect of healthcare by changing the look and feel of billing statements, introducing new ways for patients to pay their portion of care, and presenting payment options in a way that is easily understood. We understand patients are consumers who have a voice and choice in their healthcare.

Consolidating to a single patient bill was a huge undertaking. The project team had to resolve issues including non-standard patient liability cycles, how to account for different payment options across ambulatory and acute care settings, and determining who gets paid first – the physician or the hospital. The first step was to centralize ambulatory and acute care collections services creating a single contact approach for our patients as well as centralizing our patient call center and establishing a Novant Health patient experience as compared to an ambulatory or acute care experience. Once this was completed, we used a single patient statement vendor capable of meeting the organization’s needs.

The changes Novant Health has been making align with what we’ve heard from our community. A consumer survey showed that clear, concise pricing; same-day appointments, and extended hours ranked in the top-five of most appealing “value-adds,” slightly above sharing clinical information.

When it comes to the financial aspect of Novant Health, we talk about our “Revenue Cycle Revolution.” We may not be able to impact the clinical care process, but we can ensure continued on page 40
that patients have a positive financial experience. Therefore, patient advocacy is at the heart of Novant Health’s consumer focus. We concentrate on those patients who want to pay their portion of care. We’ve improved our processes related to presenting financial assistance options to patients in a consistent manner and ensuring that these options are easily understood.

Internally, Novant Health underwent a rigorous process to review and revise our financial policies — ensuring transparency and consistency — and now we offer a host of options to satisfy patient liability. The Customer Care Center is devoted to proactive outreach and leverages a new cloud dialer system to contact patients. We’re able to ensure that they understand what they will owe for their portion of care and, as appropriate, direct those in need to financial assistance. The team also comprises staff members who are focused on Medicaid and disability assistance. Our goal is to ensure that we are as proactive as possible in all aspects of patient engagement. These efforts pay off; patient collections increased $41.4 million year-over-year 2015 to 2016.

The changes Novant Health has been making align with what we’ve heard from our community. A consumer survey showed that clear, concise pricing; same-day appointments, and extended hours ranked in the top-five of most appealing “value-adds,” slightly above sharing clinical information.

Loan Program Elevates Financial Counseling Conversation

In addition to financial assistance programs, Novant Health also offers patients the option of repaying their cost of care with a zero-interest loan program. The loan program enables financial counselors to elevate their conversation and offer patients reasonable payment options. Our patients are more satisfied knowing what they will likely owe ahead of time and that they have an affordable repayment option. Our hope is to give patients peace of mind to focus on their care and recovery. The loan program also has been an effective tool for Novant Health’s shared services team. Establishing strategic relationships and extending benefits, such as the patient loan program to our partners enables us to remain competitive and attractive to consumers who are evaluating hospitals based on cost, quality and convenience.

Novant Health converted from an internal interest-bearing loan program to the zero-interest outsourced option in 2012. We continue to see ROI year-after-year. In 2016 the program helped us reduce bad debt from patient pay by $15 million and we improved operating income by $11 million. The health system has boosted patient satisfaction as well. According to survey of Novant Health patients who use the loan program, 91% said they would return for future services and 85% said they would recommend Novant Health to family and friends.

About the Author
April York is Senior Director of Patient Financial Services, Novant Health. She is active in HFMA and currently serves as treasurer for the North Carolina Chapter.

Join April for her presentation, "Making Care Affordable Without Sacrificing Financial Performance," on Wednesday, October 4th at 4p.m. in Studio 3.
Creating a New Mindset – Fully Embracing Revenue Integrity

Introduction
Revenue integrity is an exciting addition to the existing healthcare revenue cycle process. Revenue integrity brings together a holistic focus on our responsibility to ensure appropriate billing and compliance in all financial aspects of healthcare.

Revenue integrity has ushered in an elevated level of awareness to healthcare financial organizations along with improved healthcare delivery.

Although, the concept of revenue integrity is still fairly new, it has proven to be a catalyst for change both in the financial and clinical functions of hospitals and doctors’ offices.

What is Revenue Integrity and why is it important?
Revenue integrity includes ensuring compliance, coding accuracy, appropriate charge capture and reasonable pricing for services provided.

Revenue integrity has certainly garnered “buzz” in healthcare. At its inception, many were confused by the name and even wondered how it was different from traditional revenue cycle functions.

Revenue cycle teams have the primary focus of identifying issues that may hold up a bill, resolving those issues and getting the bill out the door as soon as possible.

This differs from a revenue integrity team, which is tasked with educating staff and proactively identifying workflow issues. As the name implies, identifying all facets that could prevent a high level of revenue integrity from being achieved is core to the mission.

The highly skilled members of revenue integrity teams must understand both the back- and front-end billing processes. This unique combination of experience gives them the insight to identify and overcome roadblocks to achieving consistent integrity in revenue.

It is a new way of viewing and working with some of the most important stakeholders in healthcare, our clinical partners. Revenue integrity professionals no longer spend their entire time working from a desk located in a building apart from clinical staff - they now interact regularly with clinicians in the space they occupy.

For example, suppose an issue with supply scanning/charging is identified. In the past, there may have been a one-sided meeting with the department director to discuss the importance of scanning. Now, it is more likely that revenue integrity team members visit front-line clinicians to identify barriers to accurately capturing supply charges. This approach builds partnerships between departments and ensures a more efficient workflow.

Assuring revenue integrity is critical in these changing times. Healthcare providers are being challenged to do more with less while treating a higher flow of patients. Increasing healthcare capital costs and the potential of fewer patients being covered by insurance compound these challenges. Healthcare providers must strive to maintain quality and ensure the highest integrity in revenue capture so they can continue to fulfill their missions.

Sustaining a highly-functioning revenue integrity service line:
There are four key components to creating and sustaining a successful Revenue Integrity department:
1. Identify the service line’s primary objectives
2. Recruit the right individuals to achieve the objectives
3. Be forward-thinking and identify industry opportunities and needs
4. Plan on continuing education

continued on page 42
Identifying the Objectives:
Although the name revenue integrity is used commonly throughout the industry, there are various objectives that organizations attach to their revenue integrity service line functions. For example:

- Increase revenue
- Manage supply costs
- Minimize usage of high cost drugs and implants that are not medically necessary
- Control waste
- Eliminate redundancy in charging and documentation practices
- Develop more proficient workflows

All of these items are equally important, but there is really only one objective that a highly-functioning revenue integrity department should have that includes all of these: ensuring complete integrity in revenue at all times.

Recruiting the Right Individuals to Achieve the Objectives:
As any good leader knows, the team around you is a major factor in whether or not you will achieve your objectives. Of course, your service line needs to consist of a strong leadership team including coders, compliance, charge, and compliance analysts. However, the most important attribute for team members is their level of personal integrity.

As a first step, organizations should create a team — or at least a taskforce — to tackle the issue. This may include someone from your patient financial services department, revenue cycle team, and health information management group. A nursing leader is important to make sure that you have a clinical perspective. You want to be certain that any changes you put in place will work for clinical staff—a clinical leader can let you know what’s possible and realistic. Along with the clinical perspective, you should also have an executive financial leader on the team, so he or she can reinforce the criticality of the work and ensure the organization takes it seriously.

Be Forward-Thinking:
Many providers are venturing into new services to help replace lost revenue from other areas. Although this is a common strategy, it leaves providers vulnerable to the potential of breaking guidelines they may not be familiar with.

Align the specialized compliance and billing experience of revenue integrity staff with revenue generating service lines to ensure compliance with established guidelines. If this is not a task that can be handled in-house, reach out to a reputable outside partner that can help guide your organization through the process and ensure integrity in your revenue.

Plan on continuing education:
Have a plan for education and follow up. Organizations frequently do a good job on initial education but there is a lot of turnover in healthcare, especially in leadership positions, and there needs to be a process for educating a new leader when he or she arrives.

This can involve having the new leader meet with the revenue integrity director to review department objectives, helping the new leader appreciate the importance of the revenue integrity function. By building the relationship early on, the two leaders can work collaboratively to reach desired outcomes. It's also helpful for the new leader to share any solutions and best practices that he or she brings from previous experience.

Revenue integrity includes ensuring compliance, coding accuracy, appropriate charge capture and reasonable pricing for services provided.

Conclusion
Because revenue integrity will continue to play a vital role in healthcare, it is crucial that we understand what it is, why it is important, and the steps it takes to build a successful service line.

It is imperative to keep an open mind and be willing to explore innovative approaches to engaging and educating everyone involved in the healthcare cycle. Take the time to ensure that all areas feel involved and understand the critical mission of achieving optimal revenue integrity.

A truly educated and engaged team will help pave the road to establishing and maintaining a culture centered on ensuring revenue integrity.

About the Author
Kristi Morris is the former Director of Revenue Integrity Services for Besler Consulting.
Determining If The Provider-Sponsored Health Plan Path Is Right for You

by John Tam and Ken Wood

Providers have historically lacked control over the ability to tie meaningful quality metrics to reimbursement, and some would put this at the top of the list of issues that hamper their success. After all, it is the providers on the frontlines of care delivery who can truly manage medical costs and quality for patients, as they have a unique set of controls only they can execute.

Couple that desire for more control with the industry’s continual shift toward value-based care, and more and more providers are seeing the true value in assuming risk. Some are even wondering if they should launch their own health plans. A provider-sponsored health plan (PSHP) represents the ultimate value-based care or risk arrangement. Simply defined, a PSHP is an organization of individual practitioners, ancillary service providers and/or hospitals that come together to design and run their own health plan. These provider PSHP’s are completely responsible for all aspects of costs, quality, network configuration, benefit design and other activities associated with providing health insurance to their members. Those succeeding — well-known national players like Intermountain and Kaiser Permanente, regional leaders like Driscoll Children’s Health Plan in Texas and Alliant Health Plans in Georgia, and the more than 250 other PSHPs currently operating in the U.S. — have showcased the potential for upside rewards. PSHPs can also offer some distinct advantages over other types of health plans, such as more effective population health management. Some studies suggest that PSHPs are more efficient, paving the way for lower premiums and other incentives that benefit their members.

But let’s be frank: PSHPs are not for the faint of heart, and many of us remember PSHPs that failed in the 1990s. Becoming a traditional PSHP is a massive undertaking and requires getting to scale in a way that not all providers’ market dynamics will support. Although some groups will decide to move forward with the creation of a full-blown PSHP, others will find they’re left with gaps to fill and aren’t quite ready. Yet, they still want to take on more risk. So then what?

Evaluating Your Risk-taking Capabilities: Nine Critical Considerations

Fortunately, advances in technology, business intelligence and information-sharing platforms are opening new opportunities for new PSHP players. There are more tools available today to help all types of health-care organizations aggregate the necessary capabilities to design, build and successfully run a PSHP. The question then becomes which tools you have in house and which ones you need to contract for or otherwise acquire.

Having had the opportunity to work for and alongside some successful PSHPs, here are nine critical business considerations your organization needs to honestly discuss and deeply analyze to determine if becoming PSHP is a viable option for you:

- Identify the potential network size and types of providers you will need
- Evaluate your change management capabilities
- Analyze the organization’s market position and local competition

continued on page 44
continued from page 43

- Assess local payer reaction
- Gauge consumers’ buy-in
- Investigate your specific regulatory environment
- Consider costs and financial realities
- Evaluate different sales options
- Assess your insurance IQ

Accurately and objectively analyzing these considerations are crucial to gauging the potential success of your risk-taking endeavor and determine whether and how to ultimately move forward.

For those groups who identify capability gaps and aren’t sure how to fill them, partnering with a third party could be a viable option.

A partnership with a traditional commercial payer, for example, can offer the license, capital, scaled infrastructure and expertise that eases your own administrative burden and can provide advanced regulatory knowledge and insight. Such an arrangement requires careful consideration of the potential partner, as some provider independence will necessarily be lost. It’s also important to consider how any new arrangements could impact your strategic relationships with other payers in your local market.

Industry Shifts Pave Way for Emergence of Neutral Payers

Other options have emerged as the health paradigm has shifted. Although we’re conditioned to think of payers as either state or federal government or the historical private commercial types, a new third category of payer has emerged in recent years. Purpose-built for a value-based care paradigm and for data-driven population health initiatives, these “neutral payers” have collectively raised $1 billion in capital to solve the unmet needs of providers and patients. Neutral payers offer a different approach for providers who might not be ready to launch their own PSHP and aren’t keen on partnering with a traditional payer. Some key advantages and benefits to partnering with a neutral payer include:

- Innovative consumer technology
- Collaborative mindset and a desire to disrupt legacy incumbents, which may lead to more favorable deal terms for providers
- Customizable approaches, such as co-branding or white-labeling insurance plans with provider systems that have prominent brands
- Openness to exclusivity because there is no historical relationships to maintain
- Robust change management capabilities combined with on-the-ground physician and staff training and reinforcement
- A third party’s ability to ensure incentives align with your physicians', staff’s, and overall business's needs and goals

There are also potential challenges. Most neutral payers lack the brand recognition of their larger counterparts. Some have less of a track record and balance sheet, creating uncertainty about their longevity.

The good news is that after you conduct your feasibility study and weigh the advantages and benefits against challenges, you will be steeped in critical value-based care information and ready to take on greater amounts of risk, either on your own or with a partner. And for those groups that decide to pursue a full-blown PSHP or partner with a traditional or neutral payer, you’ll have much of the information you need to fine-tune your risk-taking appetite.

About the Author
John Tam is Executive Vice President of Strategy and Ken Wood is Senior Vice President of Health Plan Development for Evolent Health. Reach them at JTam@EvolentHealth.com and KWood@EvolentHealth.com.
Revenue Integrity Forum Hosts Successful Educational Event

Keep Calm and Get it Right was the theme of the Revenue Integrity Forum’s annual educational conference held on June 13th at the Pines Manor in Edison. There were over 80 participants representing 49 hospitals in attendance. The success of the event can be attributed to the wealth of information and interactive discussions on topics including building Revenue Integrity Departments, the role of the Claims Defense Auditor, how to prevent medical necessity denials, observation versus inpatient status, and clinical documentation integrity. Amongst the speakers were some familiar names to NJ HFMA including Vickie McElarney (Craneware), past chair of our NJ HFMA Revenue Integrity Forum, Dr. Ronald Hirsch (R1 RCM, Inc.), Dr. Edward J. Niewiadomski, (Physician Advisor On-Call) and Jane Ann Sheehan (JAS & Associates), a panel moderator. Additional speakers that provided their industry expertise included Kristi Morris (formerly of Besler Consulting), Charlotte Kohler (Kohler Healthcare Consulting, Inc.), Nita Mangat (Deloitte & Touche, LLP) and MeShawn Foster (Deloitte & Touche, LLP).

Honorable mention goes to Steve Aaron of HBCS and Kate Walsh with RWJ Barnabas Health System. Steve provided free headshots to all participants and Kate organized a fund raising effort for Metuchen Elks Lodge #1914. All donations, totaling $661, went to the Elks Veterans Service Commission which provides events and services for veterans in Middlesex County.

The educational session was followed by successful Speed Mentoring and Networking Events sponsored by the NJ HFMA Chapter.

A heartfelt thank you to all of the vendors who generously supported the event as they are an integral part of the event and chapter. They included: Craneware, Capio Partners, Jzanus, HBCS, Arcadia Recovery, Callagy Law, FBCS, PATHS and Promedical. Kudos to Helene O’Donnell of Capio Partners on a job well done as the emcee for the day. Many thanks to the Revenue Integrity Forum Subcommittee members for all of their time and dedication that went in to planning and executing the event: Nora Burdi, Jennifer Gillooly, Edlynn Lewis, John ‘Jay’ Mullaney, Helene O’Donnell, Christine Puttermen, Eric Shubin, Justine Sponziello, Heather Stanisci, Kate Walsh, Betsy Weiss, as well as Tracy Davison-Dicanto, our Board Liaison.

About the Author
Betsy Weiss, RN, MPH is the Director, Revenue Cycle at St. Francis Medical Center in Trenton, NJ. She was Chair of the Revenue Integrity Forum’s 2015-2016 season. Betsy can be reached at BWeiss@stfrancismedical.org.
2017 Chapter Internal Financial Review

HFMA requires that each chapter conduct either an independent audit or a HFMA Internal Financial Review. The HFMA Internal Financial Review process and reporting was 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 also be completed by an individual or individuals possessing the appropriate financial experience and who are not involved in the chapter’s bookkeeping activity.

The purpose of the Internal Financial Review is to test and validate the chapter’s fiscal integrity and operating guidelines. Furthermore, the review:

- Addresses whether the chapter’s financial statements correctly reflect its activities for the year.
- Considers 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 2016-2017 Chapter Year was completed on a voluntary basis by a certified public accountant who is a member of the chapter. The Chapter Treasurer, 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 Committee was held to review the findings and the questionnaire. Upon review, the Audit Committee accepted the Internal Financial Review findings and approved the final financial statements for the 2016-2017 Chapter Year.

The accompanying balance sheets and statements of activities and cash flows for the years ended May 31, 2017, 2016 and 2015 reflect the final financial statements for the NJ Chapter. If you should have any questions, please feel free to reach out to any Board member for assistance.

I extend my congratulations to the chapter on another successful year.

Respectfully submitted,

Heather L. Weber
2016-2017 Audit Committee Chair
NJ HFMA
# Healthcare Financial Management Association - New Jersey Chapter
## Balance Sheets

### May 31

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<td>4,346</td>
<td>3,591</td>
</tr>
<tr>
<td><strong>Total current liabilities</strong></td>
<td>117,932</td>
<td>105,973</td>
<td>119,688</td>
</tr>
<tr>
<td><strong>Total liabilities</strong></td>
<td>117,932</td>
<td>105,973</td>
<td>119,688</td>
</tr>
<tr>
<td><strong>Net assets</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unrestricted net assets</td>
<td>297,887</td>
<td>264,483</td>
<td>211,564</td>
</tr>
<tr>
<td><strong>Total liabilities and net assets</strong></td>
<td>415,819</td>
<td>370,456</td>
<td>331,252</td>
</tr>
</tbody>
</table>
### Healthcare Financial Management Association - New Jersey Chapter

#### Statements of Activities

<table>
<thead>
<tr>
<th>Year ended May</th>
<th>2017</th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meeting and education income</td>
<td>212,873</td>
<td>240,672</td>
<td>242,996</td>
</tr>
<tr>
<td>Newsletter income</td>
<td>33,486</td>
<td>38,548</td>
<td>42,980</td>
</tr>
<tr>
<td>Golf Outing Income</td>
<td>57,215</td>
<td>65,050</td>
<td>60,750</td>
</tr>
<tr>
<td>General sponsorship income</td>
<td>235,950</td>
<td>238,866</td>
<td>191,385</td>
</tr>
<tr>
<td>Interest income</td>
<td>303</td>
<td>249</td>
<td>304</td>
</tr>
<tr>
<td>Other income</td>
<td>29,247</td>
<td>30,190</td>
<td>29,330</td>
</tr>
<tr>
<td><strong>Total income</strong></td>
<td>569,074</td>
<td>613,575</td>
<td>567,745</td>
</tr>
</tbody>
</table>

| **Expenses**   |            |            |            |
| Meeting and education expenses | 375,961    | 384,667    | 350,316    |
| Newsletter expenses | 29,308     | 32,251     | 35,544     |
| Golf Outing expenses | 53,319     | 56,344     | 59,491     |
| Member recognition and social event expenses | 10,869     | 16,041     | 7,666      |
| General and administration expenses | 64,908     | 71,363     | 71,406     |
| Depreciation   | -          | -          | -          |
| (Recovery of) provision for bad debts | 1,305      | (10)       | (63)       |
| **Total expenses** | 535,670    | 560,656    | 524,360    |

|  | **Net Operating Income** | 33,404 | 52,919 | 43,385 |

|  | **Net (loss) income** | 33,404 | 52,919 | 43,385 |

#### Healthcare Financial Management Association - New Jersey Chapter

#### Statement of Cash Flows

<table>
<thead>
<tr>
<th>Year ended May</th>
<th>2017</th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Operating activities</strong></td>
<td>33,404</td>
<td>52,919</td>
<td>43,385</td>
</tr>
<tr>
<td>Net income (loss)</td>
<td>33,404</td>
<td>52,919</td>
<td>43,385</td>
</tr>
<tr>
<td>Adjustments to reconcile net income (loss) to net cash provided by (used in) operations:</td>
<td>33,404</td>
<td>52,919</td>
<td>43,385</td>
</tr>
<tr>
<td>Accounts receivable, net</td>
<td>(9,502)</td>
<td>449</td>
<td>(6,091)</td>
</tr>
<tr>
<td>Other current assets</td>
<td>5,906</td>
<td>(15,012)</td>
<td>(7,742)</td>
</tr>
<tr>
<td>Depreciation</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Accounts payable</td>
<td>(1,729)</td>
<td>(10,700)</td>
<td>25,878</td>
</tr>
<tr>
<td>Deferred Revenue</td>
<td>13,695</td>
<td>(3,770)</td>
<td>(6,135)</td>
</tr>
<tr>
<td>Accrued Payroll</td>
<td>(7)</td>
<td>755</td>
<td>(1,115)</td>
</tr>
<tr>
<td><strong>Net cash provided by (used in) operating activities</strong></td>
<td>41,767</td>
<td>24,641</td>
<td>48,180</td>
</tr>
</tbody>
</table>

| Cash at beginning of period | 325,957 | 301,316 | 253,136 |
| Cash at end of period       | 367,724 | 325,957 | 301,316 |
New Jersey Healthcare Financial Management Association
2016-17 Chapter Awards Listing

Medal of Honor
Michael McKeever
Heather Weber

President's Award
Brittany Pickell
Deborah Carlino

YERGER Awards:
Enhancing Educational Content During Regularly Scheduled Meetings of the Patient Access Services Committee
Maria Lopes-Tyburczy
Belinda Puglisi
Lisa Weinstein

Improvement Yerger Women's Session Inclusion of Male Speakers
Heather Stanisci

Collaboration Yerger for Physician Practice Issues Forum/MGMA
Deb Carlino
Heather Weber
Megan Byrne

Enhanced Webinar Program
Sandra Gubbine
Heather Weber
Stacey Medeiros
Mary Cronin

R3 Summit
Tracy Davison-Dicanto
Stacey Medeiros

Sister Mary Gerald Bronze Awards of Excellence for Education
Stacey Medeiros
Sandra Gubbine
Mary Cronin

Founders Merit Award - BRONZE
A. Christine Putterman, CHFP
John Smith
Karen Henderson
Peter Demos

Founders Merit Award - SILVER
Brian Herdman
Charles Hehn
Fred Molinari
Scott Besler

Founders Merit Award - GOLD
Stacey Medeiros, CHFP

The Thrive Award
Amina Razanica
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Hear from BESLER’s experts at these sessions during the 2017 Annual Institute:

Wednesday, October 4th
3:00 PM - 3:50 PM: Breakout Sessions - Boardroom
Wage Index: New and Improved?
Scott Besler
Senior Manager – Reimbursement

Thursday, October 5th
12:30 PM - 1:20 PM: Lunch and Learns – Studio #2
Creating a New Mindset: Fully Embracing a Revenue Integrity Culture
Kristi Morris
Director, Revenue Integrity Services

How does your denial rate compare to your peers?

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- Improve Collections by 1% NPSR
- Reduce Aged AR

Be part of this discussion with Colburn Hill Group at the NJ HFMA Annual Institute on Thursday, October 5th at 1 p.m.

Colburn Hill Group
Revenue Cycle Management
Results, not reports

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A combination of federal requirements in recent years has increased the number of Americans who have health insurance coverage for behavioral health services. The Affordable Care Act (ACA) expanded coverage by requiring that most individual and small employer health insurance plans cover MH/SUD services as one of 10 Essential Health Benefits (EHB). The ACA’s implementing regulations require plans to comply with parity to satisfy the ACA’s EHB requirement. The ACA also requires most plans to cover preventive health services at no charge, including depression screenings for adults and behavioral assessments for children, and prohibits most plans from denying coverage or charging more for preexisting conditions, including behavioral health conditions. States that participated in Medicaid expansion further expanded access to behavioral health coverage.

As a result, a recent White House Parity Task Force Report estimates that “the combined reach of The Mental Health Parity and Addiction Equity Act (MHPAEA), the ACA and the application of parity in Medicaid plans has touched the health insurance coverage of approximately 174 million people.”

Despite these improvements in coverage of behavioral health conditions, however, disturbingly high percentages of Americans continue to report difficulty accessing needed behavioral health care. A survey by Mental Health America found that more than 50% of adults with mental illness do not receive treatment. The reasons are varied, including that available networks of behavioral health providers are inadequate to meet growing demand. Advocates also point to continued stigma and exacting utilization management tools, including fail-first and prior authorization requirements. While several questions and debates persist, one thing is clear — having coverage does not equal access to behavioral health treatment.

Behavioral health parity is a vital tool for helping consumers gain access to needed behavioral health treatment. The Mental Health Parity and Addiction Equity Act of 2008 is among the first laws to go beyond merely regulating the terms of coverage to explore how plans manage health care. It requires plans to examine their processes for establishing benefits and cost-sharing requirements and making medical necessity and coverage determinations for medical/surgical as well as MH/SUD services to ensure parity.

Compliance with parity, however, is challenging to implement and monitor because it requires judgment regarding whether plans are using comparable processes and strategies to determine which MH/SUD and medical/surgical benefits to cover and in what circumstances. Regulators, plans, and advocates are wrestling with thorny implementation questions. Parity is inherently comparative, but it is not always clear what the relevant comparators are. Some MH/SUD services, such as applied behavioral analysis (ABA) services for patients with autism, do not have a clear medical/surgical analogue. Parity compliance often is not apparent from the surface of plan documents or regulatory filings and instead requires nuanced, granular assessment of plan data and processes. Non-quantitative treatment limitations (NQTLs) pose an especially vexing implementation challenge. Parity must be assessed both in plan terms as written and in operation, which poses additional challenges to regulators.

Although federal regulators have issued a considerable amount of parity guidance to date, there is general agreement among plans, advocates, and states that federal regulators need to issue additional clarifying guidance to help guide parity implementation. Existing guidance too often glosses over challenging issues and is inadequately specific. The 21st Century Cures Act requires federal agencies to release a new parity compliance program guidance document by December 13, 2017, which must include illustrative, de-identified examples. The Act further requires the development of an enforcement action plan and the issuance of additional guidance for plans and beneficiaries regarding compliance with disclosure and NQTL requirements. Stakeholders should seek out opportunities to influence the development of these documents so that they meaningfully address implementation challenges.

New Jersey has not yet committed resources to meaningful parity monitoring and enforcement. Pending legislation would require detailed plan filings that are carefully keyed to parity’s technical requirements, which would facilitate regulatory oversight of parity compliance. Stakeholders can partner with entities like the New Jersey Parity Coalition to advocate for sensible reforms.

Providers and consumers also can aid parity compliance monitoring by utilizing complaint portals to alert regulators and advocates to denied claims. Not every denied behavioral health claim violates parity, of course. But by reporting denials, regulators and advocates are better positioned to track denials for warning signs that warrant closer scrutiny for parity compliance.

We also need to build and foster collaborative learning communities among stakeholders and regulators to ensure that ongoing, productive dialogue continues. By raising implementation challenges and engaging one another in constructive dialogue about what parity means and requires, we will identify gaps in parity guidance and build a workable parity compliance framework.

About the author
Tara Adams Ragone is an Assistant Professor in the Center for Health & Pharmaceutical Law & Policy at Seton Hall University School of Law. She serves on a number of advisory committees, including the ClearHealth Quality Institute Mental Health Parity Accreditation Program’s Parity Standards Committee, the New Jersey iPHD Advisory Committee, and the Good Care Collaborative’s Steering Committee. Tara can be reached at Tara.Ragone@shu.edu.
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