hfma new jersey chapter
healthcare financial management association

Spring 2017 • vol 63 • num 3

garden state focus

national excellence award winner

Taking Action on the Opium Epidemic:

- **New State Legislation Expands Coverage for Drug Rehabilitation Services**
  See page 6
- **New Pathways to Care for Substance Use Disorder Patients**
  See page 9

UPCOMING EVENTS

Mark your calendar!

Women's Leadership and Development Session: Learn, Laugh, Relax – Words of Wisdom for Success!

April 20, 2017 DoubleTree by Hilton Tinton Falls

***Presented by* the Education Committee**

2017 Spring Education Sessions

April 26, 2017, 8:30 am-12 pm – North RWJ Barnabas Health

April 28, 2017, 12:30 pm-4 pm – South AtlantiCare Life Center Building

Annual Golf Outing

May 9, 2017 Fiddler's Elbow Country Club

Financial Education for Clinicians

May 11, 2017 New Jersey Hospital Association

***Presented by* the Education Committee**

2017 *Industry Update*

May 23, 2017 Pines Manor

***Presented by* the Payer and Provider Collaborative Committee**

2017 *Industry Update*

June 13, 2017 Pines Manor

***Presented by* the Revenue Integrity Committee**

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DEADLINE FOR SUBMISSION OF MATERIAL

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

IDENTIFICATION STATEMENT

Garden State "FOCUS" (ISSN#1078-7038; USPS #003-208) is published bimonthly by the New Jersey Chapter of the Healthcare Financial Management Association, c/o Elizabeth G. Litten, Esq., Fox Rothschild, LLP, 997 Lenox Drive, Building 3, Lawrenceville, NJ 08648-2311

Periodical postage paid at Trenton, NJ 08650. POSTMASTER: Send address change to Garden State "FOCUS" c/o Laura A. Hess, FHFMA, Chapter Administrator, Healthcare Financial Management Association, NJ Chapter, P.O. Box 6422, Bridgewater, NJ 08807

OBJECTIVE

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

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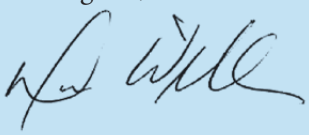
The President's View . . .

Dan Willis

It is unbelievable to realize that it is April already and my term as President is nearly over. The past year has been one of the highlights of my career. Just think about it, having the honor and privilege of leading this outstanding organization and moving it forward into the future. Obviously, this doesn't happen without the help of many people and without the support of the Board. I would like to thank the Board and in particular those members that are rolling off this year for their many years of service: John Brault, Josette Portalatin, Kevin Joyce and Belinda Doyle Puglisi, it has been my pleasure working with each of you over the years. I would also like to thank our Garden State Focus Editor, Elizabeth Litten, for her many years at the helm of this magazine and the wonderful job she has done. We are thankful that Elizabeth will be staying on with the Communications committee but in a less involved capacity.

We have many upcoming opportunities for our member to Learn and Network and I look forward to seeing you at one of them in the near future.

Best regards,



April 20, 2017 **Learn, Laugh, Relax - Words of Wisdom for Success!**
DoubleTree by Hilton Hotel Tinton Falls – Eatontown
Women's Leadership and Development Session

2017 Spring Education Event: What Does the Road Ahead Look Like for Healthcare?

April 26, 2017 8:30 AM to 12:00 PM **North Jersey Location**
RWJ Barnabas Health Oceanport
2 Crescent Place
Oceanport, NJ

April 28, 2017 12:30 PM to 4:00 PM **South Jersey Location**
AtlantiCare Life Center Building
2500 English Creek Road
Egg Harbor Township, NJ

May 09, 2017 **2017 Golf Classic**
Fiddler's Elbow Country Club
811 Rattlesnake Bridge Road
Bedminster Township, NJ 07921

May 11, 2017 **Finance Education for Clinicians**
New Jersey Hospital Association
760 Alexander Road
Princeton, NJ 08540

May 11, 2017 **Networking Event with Speed Mentoring at The Watermark in Asbury Park.**

May 23, 2017 **Payor Provider Collaboration Committee Education Session at Pine Manor**

June 13, 2017 **Revenue Integrity Committee Education Session at Pines Manor including Speed Mentoring.**

thrive

From The Editor . . .

Elizabeth G. Litten

Dear Readers,

The feeling I have as I write this letter on the last day possible (the issue will go to print later today, most likely) is not unlike the feeling I had when I said goodbye to my youngest child outside his college dorm freshman year. I have served as Editor of this magazine since 1996 (with a brief hiatus in the early 2000s, when I served on this Chapter's Board), so the duration of my role in the position is roughly equivalent to the typical duration between birth and enrollment in college. Letting go of this often challenging, but always rewarding (though completely uncompensated) role is bittersweet.

Not long after agreeing to serve as firm-wide HIPAA Privacy Officer for my law firm, and shortly before agreeing also to serve as firm-wide HIPAA Security Officer, I realized that my longstanding passion for this magazine and commitment to our Chapter had to be balanced against my increased time and energy demands. I also strongly believe that change can be very beneficial, and I am extremely grateful to CBIZ KA colleagues and long-time HFMA members Brian Herdman and Adam Abramowitz for agreeing to take over for me. I promised them and the rest of our wonderful Communications Committee that I would remain an active Committee member. I will continue to brainstorm with them for article ideas, elicit article contributors, review the magazine proofs, and add my two cents when it comes to cover ideas, event coverage, and anything else related to producing a high-caliber magazine covering New Jersey and national health care industry news relevant to our members.

Brian Herdman, a member of the NJ HFMA Board of Directors, currently serves as the Board liaison to the Communications Committee and is a familiar name and face to many of our Chapter's members. Brian is an operations manager of financial reimbursement services at CBIZ KA, where he develops new programs and products that contribute to hospitals' understanding of resource utilization, coding risk exposure, and managed care.

Adam Abramowitz, while active in the Philadelphia Chapter of HFMA, may be a new name to some NJ HFMA members. Adam is a senior manager for marketing and sales at CBIZ KA. He is a native of Cherry Hill, NJ and lives in Philadelphia. He received a B.A. from Emory University in political science and creative writing and an MBA from Temple University with a concentration in strategic management. Adam has worked at CBIZ for 11 years. Prior to his time in healthcare, he worked in New Jersey politics as a speechwriter and policy coordinator. He is an avid guitar player and plays hockey in a weekly league.

Thank you, Brian and Adam, for agreeing to take over as co-Chairs of the Communications Committee and co-Editors of this magazine. Thank you (thank you, thank you!!), Laura Hess, for having made my tenure as Editor manageable, and thanks to the entire Committee for your inspiration, entertainment and friendship. Thanks, also, to Joe Fallon of Hermitage Press, for faithfully attending and contributing to our Committee meetings.

Most of all, thank you, Readers, for consistently ranking this magazine and our Chapter's communications as a key benefit of your HFMA membership. Happy reading!

Elizabeth G. Litten
Editor

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Moving the Needle Forward: N.J. Senate Bill Reforming Health Insurance Coverage for Drug Rehabilitation Passes

Patrick N.C. Thurber

by Patrick N.C. Thurber

On February 15, 2017, New Jersey Governor Chris Christie signed a bill into law that contains far-reaching reforms designed to ease the pathways to drug rehabilitation treatment as well as reduce access to opioids and other Schedule II controlled substances. New Jersey, like many states throughout the country, has seen the number of deaths caused by drug overdoses – especially opiates – skyrocket over the past several years. Since 2010, deaths from heroin and morphine in New Jersey have risen by an alarming 214 percent.[1] In 2015 alone, drugs killed almost 1,600 people throughout the State– more than four times the number of murders in New Jersey in the same year.[2] In the State of the State address delivered this past January, Governor Christie cited these figures and a raft of others in terming this phenomenon an "epidemic ravaging our state and its people."[3] He urged the Assembly and the Senate to pass legislation designed to tackle this crisis and a week later signed Executive Order 219, declaring the opioid epidemic a public health crisis in New Jersey.[4]

The law has three key components: mandating that insurance companies provide certain minimum coverage requirements for drug rehabilitation benefits, imposing limits on prescriptions of certain opiates and other Schedule II controlled substances and requiring that certain health care professionals receive special training related to opiate addiction. While the legislation has been widely heralded for its bold reforms, some critics have highlighted some shortfalls. For one, the law's fiscal impact as well as its impact on health insurance premiums throughout New Jersey are currently unknown. Additionally, the coverage requirements the law establishes will only benefit the 30 percent of New Jersey residents who have health insurance policies that are regulated by the State. Nonetheless, the legislation provides a very strong foundation from which legislators can enact further reforms, provided the momentum Governor Christie has supplied is not lost in the interim.

Mandatory Coverage Requirements

Arguably, the boldest reforms of the legislation are the mandatory coverage requirements related to drug rehabilitation benefits imposed on health insurance companies. The statute requires that insurance companies provide coverage for up to 180 days per plan year of inpatient and outpatient treatment of substance use disorder upon a practitioner's determination that those services are medically necessary. Additionally, providers who treat substance abuse disorders cannot require pre-payment – on top of any co-payment, deductible or co-insurance – of medical expenses during those 180 days.

The law prohibits any retrospective review or concurrent review for the first 28 days of inpatient services provided. Once that 28-day period has elapsed, insurance companies can conduct concurrent review of the medical necessity of services provided once every two weeks. Concurrent review is defined in the statute as the review of inpatient services as they are provided, including the appropriateness of the care, the setting and patient progress, and as appropriate, the discharge plans.

The law similarly prohibits retrospective review of the determination of medical necessity for the first 28 days intensive outpatient services. Intensive outpatient or partial hospitalization services provided beyond this 28-day window are subject to retrospective review. The law uses inpatient days for the purpose of calculating the 180 days of coverage per plan year. Any unused inpatient days may be exchanged for two outpatient visits. Since it is not provided for in the text of the statute, the task of establishing the clinical review tool for the medical necessity review is to be established through rulemaking by the Commissioners of the Department of Human Services and the Department of Health.

Prior to the law's enactment, many insured New Jersey residents' policies contained far less generous coverages with regard to drug rehabilitation services. Additionally, the requirement of prior authorization for certain drug addiction treatments – like prescriptions of anti-addiction medications – slowed access to treatment. When a patient seeking treatment for drug addiction faces delays in receiving that treatment, an already-narrow window of potential treatment can close, sometimes forever. As a result of the law's enactment, all state-regulated insurance policies must provide at least 180 days and – perhaps as importantly – cannot require prior authorization or impose other prospective utilization management requirements before the insured begins receiving treatment.

Restrictions on Prescriptions of Opioid and Schedule II Controlled Substances

In an interview last month, Dr. Andrew Kolodny, executive director of Physicians for Responsible Opioid Prescribing, stated, "The reason we have this epidemic of opioid addiction is because beginning in the 1990s, the medical community started to prescribe opioids much more aggressively than we had in the past. And as the prescribing went up, addiction and overdose deaths went right up along with the increase in prescribing."[5] In a nod to the truthfulness of that premise, S-3 restricts how opioids and Schedule II controlled substances are prescribed, both in the duration of the initial prescription and in the strength of the particular drug being prescribed.

The law imposes the nation's strictest limits on the duration of the initial prescription of certain opioids and Schedule II controlled substances. Where a practitioner is treating acute pain, the law limits initial prescriptions of opioids to supplies of five days or less. Other states such as New York, Maine and Massachusetts have laws that limit initial prescriptions to seven days.[6] Further, where the prescription is for immediate-releasing opioids, the law requires that the prescription must be for the lowest effective dose. The law exempts patients who are in active treatment for cancer, receiving hospice care or residents of long-term care facilities from the prescription limitations.

In addition to limiting the quantity and strength of prescriptions of a Schedule II controlled substance or other opioid, the law sets forth certain protocols for practitioners. The practitioner must do the following prior to issuing a prescription for a Schedule II controlled substance or other opioid: take and document the results of a thorough medical history, including the patient's experience with non-opioid medication and non-pharmacological pain management approaches and substance abuse history; conduct, as appropriate, and document the results of a physical examination; develop a treatment plan, with particular attention focused on determining the cause of the patient's pain; access relevant prescription monitoring information under the Prescription Monitoring Program; and limit the supply of any opioid drug prescribed for acute pain to a duration of no more than five days as determined by the directed dosage and frequency of dosage.

A practitioner may issue an additional prescription for a Schedule II controlled substance or other opioid, but no sooner than four days after issuing the initial prescription. The subsequent prescription can only be issued if: the subsequent prescription would not be deemed an initial prescription under the law; the practitioner determines that the prescription is necessary and appropriate to the patient's treatment needs and documents the rationale for the issuance of the subsequent prescription; and the practitioner determines that the issuance of the subsequent prescription does not present an undue risk of abuse, addiction or diversion and documents that determination.

Lastly, prior to the initial prescription and again prior to a third prescription, if medically necessary, the practitioner must discuss with the patient, or a minor patient's parent or guardian, the risks that Schedule II controlled substances and other opioids present. The law calls upon the Division of Consumer Affairs to develop guidelines for those discussions, but specifically suggests the following topics be discussed: the risks of addiction and overdose associated with opioid drugs; the dangers of taking opioid drugs with alcohol and other depressants; the reasons why the prescription is necessary; any alternative treatments that may be available; and the highly addictive nature of opioids, even when taken as prescribed.

These measures send a strong signal that health care professionals have an important role to play in curbing the proliferation of opioids. Dr. Kolodny said the following with regard to the limits on prescriptions: "What I like about this legislation is that it demonstrates a recognition among policy makers that aggressive prescribing of opioids is fueling the epidemic."[7]

Required Training for Health Care Professionals

In addition to the establishment of requirements for patient education as to the risks associated with opioid drugs, the law mandates certain training for health care professionals, both those who have prescribing authority and even some who do not. Professionals with prescribing authority are required by the law to complete one continuing education credit on topics that include responsible prescribing practices, alternatives to opioids for managing and treatment of pain and the risks and indicators of opioid abuse, addiction and diversion. Similar requirements apply to professionals who do not have prescribing authority but interact with patients who may be prescribed opioids, such as certified nurse midwives.

While this new law's reach has its limits, it is an important opening move in improving access to drug rehabilitation services and reducing the supply of Schedule II controlled substances and opioids in New Jersey. The law's multi-layered approach is a testament to the complex nature of this particular public health crisis. The combination of measures contained in this new law should help in stanching the opioid public health crisis and reducing the recent surge in opioid-related overdoses in New Jersey.

About the author

Patrick N.C. Thurber is a health care attorney at the national law firm of Fox Rothschild LLP in their Princeton NJ office. He represents clients in various corporate and health care matters. Patrick can be reached at pthurber@foxrothschild.com.

Footnotes

[1]Christie, Christopher J. "State of the State Address 2017." New Jersey, Trenton. NJ.com. Web. 25 Feb. 2017.
[2]Christie, Christopher J. "State of the State Address 2017." New Jersey, Trenton. NJ.com. Web. 25 Feb. 2017.
[3]Christie, Christopher J. "State of the State Address 2017." New Jersey, Trenton. NJ.com. Web. 25 Feb. 2017.
[4]Christie, C. J. (2017, January 17). Executive Order 219. Retrieved February 25, 2017, from http://nj.gov/governor/news/news/552017/approved/20170117a.html
[5]Pugliese, N. (2017, February 15). Christie signs 'historic' anti-addiction legislation. Retrieved February 25, 2017, from http://www.northjersey.com/story/news/new-jersey/2017/02/15/christie-signs-historic-anti-addiction-legislation/97969356/
[6]Livio, S. K. (2017, February 15). Christie signs bill limiting painkiller prescriptions to five days. Retrieved February 25, 2017, from http://www.nj.com/politics/index.ssf/2017/02/bill_limitig_painkiller_prescription_on_christies.html
[7]Pugliese, N. (2017, February 15). Christie signs 'historic' anti-addiction legislation. Retrieved February 25, 2017, from http://www.northjersey.com/story/news/new-jersey/2017/02/15/christie-signs-historic-anti-addiction-legislation/97969356/

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Creative Designs to Service Delivery Focus on Access to Care

Mary Ditri

by Mary Ditri

Advocates for individuals in need of mental health and substance use disorder (SUD) treatment have long called for policy and practice change to improve access to care. This call to action has not been limited to one region of the state, but instead permeates all communities.

Providers across the continuum of care have prioritized the clinical and operational challenges impeding appropriate access to these services, where too often this vulnerable population is left to rely on emergency departments for care otherwise appropriate for community-based settings. For the acutely ill, the time it takes to get into an inpatient bed can be impeded by logjams outside of the control of the provider community. Over the years providers have taken the initiative to improve access to care at the local level with innovative practices designed to provide the appropriate level of care to patients without unnecessary delay.

In New Jersey, the number of emergency department visits and inpatient admissions for which mental health or SUD was the primary or secondary diagnosis increased by almost 30 percent from 2010 to 2014.

One example of innovative work began in 2013 in the south-western region of the state. Improvements to access were identified as health priorities for southern New Jersey through a Tri-County Health Needs Assessment of hospitals in Burlington, Camden and Gloucester counties. In response, five health systems – Cooper Health System, Kennedy Health, Lourdes Health System, Inspira Health Network and Virtua – joined to form the South Jersey Behavioral Health Innovation Collaborative (SJBHIC). In partnership with NJHA and subcontracting with the Camden Coalition of Healthcare Providers, the group moved forward on an otherwise unheard of effort to reform the service delivery system in their region for individuals in need of mental health/SUD care.

The hospital partners self-funded a collaborative in which these typically competitive organizations used a mixed-methods approach to understanding the quality, accessibility, capacity and coordination of mental health/SUD services for residents in their region. During their first year's work, the group completed a baseline assessment, drawing on a variety of data sources, including "hot spotting" of wrap-around, law enforcement and housing data; analysis of five years of hospital claims data; and more than 50 interviews with key stakeholders.

In New Jersey, the number of emergency department visits and inpatient admissions for which mental health or SUD was the primary or secondary diagnosis increased by almost 30 percent from 2010 to 2014. The result of the SJBHIC's first year of work told a significant story, like that of "Jane." Every day, people like Jane – a 40-year-old woman with multiple chronic conditions including mental health/SUD diagnoses – seek treatment at New Jersey hospitals. Between 2010 and 2014, Jane lived at four different addresses in South Jersey and visited hospitals in five different systems a total of 77 times. Her hospital stays totaled 294 days at a cost of $4.4 million, with the hospitals receiving $386,000 in payment. Jane's story is a real-life example of one patient struggling to navigate an outdated system where services and needs are mismatched. (See figure 1, page 10.)

Jane's situation is not unique in this region. Jane is one of more than 800 patients who visited all five SJBHIC hospital systems over the baseline study's five-year period. Of these patients, the majority had at least one mental health/SUD diagnosis, and almost half had both. Together, these patients had more than 31,000 hospital visits over the five-year span, with more than $260 million in charges to hospitals. For patients with visits to all five hospital systems in 2010, the median

continued on page 10

continued from page 9

charge was $53,633; for patients visiting five hospital systems in 2014, the median charge increased to $123,518.

Figure 1. Patients with a Mental Health or SUD Diagnosis Who Visited the Five Health Systems

	Minimum	Average	Maximum
Age	2	36 years	94
Hospital Visits	5	43 visits	434
ED Visits	2	40 visits	431
Inpatient Stays	0	3 stays	61
Days Between Visits	0	68 days	404
Stay Length	0	4 days	64
Days Spent in the Hospital	0	33 days	402
Charges	$6,928	$378,732	$4,432,220
Hospitals' Payments	$0	$45,849	$641,620
Municipalities inhabited	1	7	18
Chronic Conditions	1	7 conditions	23

In 2015, the same trend was observed statewide. Emergency department visits increased overall by more than 45 percent. The trend supports the notion that leaders must proactively move efforts forward that focus on creative solutions to care delivery models. To address this, hospital leaders nationally are pursuing strategies to increase access to mental health/SUD services, improve throughput in the emergency department and integrate behavioral and primary care services in their communities. The SJBHIC has prioritized its work, providing targeted options for patient care, embedding mental health and SUD staff in hospitals and improving care for patients at risk for repeat hospitalizations.

The SJBHIC hospitals are expanding their mental health/SUD service delivery options to more effectively target specific groups of patients, many of whom may not benefit from the current delivery structure. The teams across hospitals are working with and learning from each other as their work continues. Beyond the lessons learned from each other, where practices are being tested, spread and standardized throughout the five systems, leaders are exploring the benefits of implementing lessons learned from national models of excellence. Innovations and shared measurement systems to compare regional core quality measures and to assess collective progress helps to inform legislative support aimed at innovative, evidence-based models for care delivery.

As the collaborative members further their work to improve access to care and quality of outcomes for the communities they serve, the engagement of consumers of care, families, policy makers, providers and the stakeholder community will help inform the shaping of innovation and redesign. Through collaborative partnerships that include data-driven evaluations of service utilization and local tests of change designed to improve access to care, patient throughput and – most important – clinical outcomes for individuals in need, regions of the state are setting the stage for sustainable change beyond the acute care walls.

About the author

Mary Ditri serves as the Director of Professional Practice at the New Jersey Hospital Association. Coming aboard in 2006, Mary oversees policy and practice issues related to mental health and other quality and patient safety areas, and is the project coordinator for the NJ High Reliability Collaborative under the HRET-NJ HIIN contract. As part of the leadership team for NJHA, Mary also is the lead staffer of the association's Behavioral Health and Corporate Compliance Constituency Groups. Prior to coming to NJHA, Mary served in the Office of the Medical Director in the Department of Human Services. Before working for state government Mary was part of the hospital provider network having worked at Monmouth Medical Center and Meridian Health. Mary received her Bachelor of Science in Education and Master of Arts in Counseling from Trenton State College in Ewing, N.J. and is currently finishing up her Doctorate in Healthcare Administration. Mary can be reached at mditri@njha.com.

•Who's Who in NJ Chapter Committees•

2016-2017 Chapter Committees and Scheduled Meeting Dates

***NOTE:** Committees have use of the NJ HFMA Conference Call line. **The Call in number is (712) 432-1212**
If the committee uses the conference call line, their respective attendee codes are listed with the meeting date.

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

COMMITTEE	PHONE	DATES/TIME/ ACCESS CODE	MEETING LOCATION
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Co-Chair(s): Lisa Hartman Weinstein – lisarhartman@hotmail.com	(609) 718-9982	9:00 AM	
Deborah Carlino – carlindl@ca.rutgers.edu	(973) 972-3260	Access Code: 274-926-602	
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Andrew Webber – awebber@medixteam.com	(201) 406-1097	2:30 PM	Somerset, NJ 08873
Board Liason: Belinda Puglisi – BPuglisi@childrens-specialized.org	O: (908) 301-5458 / C: (862) 251-0753	Access code: 542-364-749	
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Regulatory & Reimbursement		Third Tuesday of each Month	
Chairman: Peter Demos – pdemos@hackensackmeridian.org	(732) 751-3378	9:00 AM	Monmouth Shores Corp. Park
Co-Chair(s): Rachel Simms – rsimms@ubhc.rutgers.edu	(732) 235-3420	(No December Meeting)	Meridian Conf. Room 1C
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CPE Designation			
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"Trumpcare" The Latest Efforts to Repeal and Replace The Affordable Care Act

James Robertson

John Kaveney

by James A. Robertson and John Kaveney

With the election of Donald Trump and the retention of power by Republicans in both the House of Representatives and Senate, changes to the Patient Protection and Affordable Care Act ("ACA") have become a focus of those in power, especially those who have been promising a repeal of the ACA. Since the election, the President has made a number of comments about various provisions of the current ACA and several members of Congress have proposed alternatives to replace the ACA. Despite House Speaker Paul Ryan's plan recently coming to the forefront and being backed by the President, its recent removal from consideration by the House of Representatives has left much up in the air concerning what "Trumpcare" might ultimately look like. As a result, it remains important to understand the various proposals being lobbied to better understand what might replace the ACA.

There are four principal frameworks that have been proposed at various points in time over the past couple years: (1) the Empowering Patients First Act by Tom Price[1], (2) A Better Way Forward by Paul Ryan[2], (3) the Patient CARE Act by Richard Burr, Fred Upton and Orrin Hatch[3], and (4) H.R. 3762[4] passed by Congress in 2016 and vetoed by then President Obama. Each alternative framework contains subtle differences from the others but in each proposal there are sweeping changes to the ACA.

Key Aspects of the ACA That Are Likely To Be Impacted

Probably the most controversial aspect of the ACA is the individual and employer mandates, which require individuals and employers over a certain size to maintain insurance for themselves and their employees, respectively, or be penalized via a tax for failing to maintain insurance. Under all of the above proposed frameworks, both mandates would be repealed. Those who believe these provisions are unconstitutional, despite the final holding by the Supreme Court to validate the individual mandate as a constitutional tax, will applaud such a change. However, it will also pose a challenge as most acknowledge that keeping costs down and health care services comprehensive require the young and healthy to be in the insurance pool to maintain the markets' financial viability. Much more debate is likely to occur on this issue in assessing the viability of any proposed replacement options.

The mandate also directly impacts the viability of the ACA's prohibition against insurers either denying coverage or charging significantly more for those with preexisting conditions (also known as guaranteed issue). Eliminating the mandate but keeping this prohibition in place would effectively allow people to buy insurance, at no greater expense, after they developed a medical condition. Insurance, however, cannot survive under such a model. Thus, in conjunction with the elimination of the mandates, each of the above proposed frameworks (except H.R. 3762) maintain guaranteed issue at standard rates but only for individuals that maintain continuous coverage. Moreover, individuals with coverage gaps may be subject to medical underwriting and assigned to high-risk pools. Thus, there will be a trade-off to eliminating the mandates to ensure the system is not abused.

One of the key changes to the ACA under each of the frameworks (except H.R. 3762) would be to revise how tax credits are provided to individuals not insured through their employer. Under the current ACA, individual income is measured and utilized to assess for how much of a tax credit an individual will qualify. In other words, the lower an individual's income, the greater the tax credit they qualify to receive. The proposed frameworks similarly provide for tax credits but make them

uniform for all individuals based on age rather than income. The one exception is the plan by Burr/Upton/Hatch that also phases out the tax credit above 300% of the federal poverty level. Many opposed to this revision to the ACA point out the lack of sensitivity to income and worry that those able to afford insurance will be receiving the same tax credit as those in poverty. There is sure to be much more debate on this point in the future as their was in debating House Speaker Ryan's bill.

These frameworks also generally eliminate all taxes under the ACA, return to the states oversight over ratings issues and plan requirements, permit the sale of insurance across state lines and expand the benefits of health savings accounts. Currently, the ACA mandates certain minimum essential health benefits for all insurance plans. The proposed frameworks all seek to eliminate these requirements thereby giving the states more control and insurers more flexibility to craft products based on customer demand rather than government mandate. These revisions all flow from a common theme of returning control over health insurance to the states and attempting to provide more options to individuals. Proponents of replacing the ACA believe these changes are necessary given the fact that many of the health insurance exchanges created under the ACA have closed or whose options have been significantly restricted following the exodus from those states of numerous insurers who determined they could not make money on the exchange. Opponents remain skeptical that plans will lack critical health services without certain minimum requirements in place and that customers will be confused and be less able to compare products without the standardization created by the ACA.

The Fate of Medicaid Expansion

In addition to the changes discussed above, one of the most impactful aspects of the proposed repeal and replace options is the elimination of Medicaid expansion. This aspect of the ACA provided reimbursement to providers for an entirely new population of patients previously uninsured, many of whom would qualify, at best, for charity care. In fact, the State of New Jersey has decreased its charity care subsidy allocation as a result of the Medicaid expansion.

If Medicaid expansion is in fact eliminated, there is likely to be some sort of transition period to allow for the necessary preparations to be made. Elimination of Medicaid expansion is likely to take the form of a repeal of both the expanded eligibility category of low-income adults with income up to 133% of the federal poverty line along with repeal of the enhanced federal funding for newly-eligible adults. Such a change would mean providers would once again lose the reimbursement for a significant population of patients as many of these individuals, even with government subsidies, cannot otherwise afford to purchase insurance. Moreover, reimbursement for the remaining Medicaid patients would decrease with the elimination of the enhanced funding. It is estimated that such a change would impact over 11 million newly eligible adults worth over $55 billion in federal funding.[5] In New Jersey alone, elimination of Medicaid expansion is expected to impact over 500,000 individuals with an estimated federal funding of over $10 billion.[6] Without this significant federal funding going to the states it remains to be seen how each state will adjust to the drop in revenue. Cuts to state programs or increases in taxes are two likely outcomes to make up the difference.

Many wonder whether anything will replace Medicaid expansion if repealed. The plans by Ryan and Burr/Upton/Hatch call for a shift in Medicaid financing to one funded by block grants or per capita caps. Such changes could allow for funding for lower-income patients as these financing mechanisms provide a fixed grant to each state (in the case of block grants) or a fixed grant based on the total Medicaid population (in the case of per capita caps) with the states then left to decide how best to run their Medicaid programs. Arguably states could then seek to expand eligibility criteria. Proponents argue this will provide greater flexibility similar to the way 1115 waiver programs allow for innovation. Opponents, however, see a decrease in overall funding, and thus, an almost certain drop in eligibility and services covered.

No doubt the ultimate impact of eliminating Medicaid expansion will turn on the details of what it is replaced with in the future. Regardless of how Medicaid expansion is changed or repealed, states, providers and patients will be forced to adapt.

What's Next?

President Trump's February 28, 2017 address to Congress identified key principles he believed were necessary for a better health care system. They included:

1. Access to coverage for all Americans with pre-existing conditions along with a stable transition for Americans currently enrolled in the healthcare exchanges.
2. Assistance to Americans to purchase their own coverage through tax credits and expanded health savings accounts with plan options that Americans want, not plans forced upon them by the government.
3. Provide state governors the resources and flexibility with Medicaid to make sure no one is left out.
4. Implement legal reforms that protect patients and doctors from unnecessary costs that drive up the price of insurance – and bring down the artificially high price of drugs.
5. Provide Americans the freedom to purchase insurance across state lines.

Shortly after the President's address, House Speaker Ryan's plan came to the forefront and as recent as March 23, 2017 was going to be presented on the floor of the House

continued on page 14

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of Representatives for a vote. However, at the last minute it was pulled due to a lack of support. In particular, the House Freedom Caucus, a coalition of conservative Republicans in the House of Representatives, refused to support the bill mainly due to concerns it continued the entitlement program created by the ACA, except in a new form. Consequently, without their support, House Speaker Ryan, and the President who had supported the bill, lacked the votes for its passage.

Many have viewed these events as a set-back for the Administration and those seeking to repeal and replace the ACA. However, despite the belief by many that the issue is now deadlocked given the Republicans' inability to unite around one bill, as recent as March 28, 2017 House Speaker Ryan indicated he intends to continue working on legislation to repeal and replace the ACA.

What many had hoped would be a swift drafting, debate and passage to repeal and replace the ACA has now become a much more deliberate and prolonged process. Given the deep divides between the various factions of the Republican Party, absent a breakthrough between the various groups it is unlikely Congress and the American people will see a vote on a final bill until at least later this year. Between now and then there is sure to be much more debate and analysis of what has and has not worked in the current ACA along with what will and will not work in the various proposals being made. It remains to be seen whether Republicans missed their opportunity and whether the shift in focus to other policy agenda items will kill momentum for those seeking to fulfill the repeal and replace campaign promise.

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Endnotes

[1]https://www.congress.gov/bill/114th-congress/senate-bill/2519/text
[2]http://paulryan.house.gov/healthcare/pca.htm
[3]https://www.finance.senate.gov/imo/media/doc/The%20Patient%20Choice,%20Affordability,%20Responsibility,%20and%20Empowerment%20Act.pdf
[4]https://www.congress.gov/bill/114th-congress/house-bill/3762
[5]Repeal of the ACA Medicaid Expansion: Critical Questions for States, State Health Reform Assistance Network, December 2016 – www.statenetwork.org
[6]Id.

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John Dalton Receives NJHA's Annual Hospital Trustee Award

John J. Dalton

Recipient of Hospital or Healthcare System Trustee of the Year Award must have demonstrated exceptional leadership, guidance and commitment to the hospital, state, and community. Through public involvement at the community, state and/or national level, the recipient must have been a strong advocate, participating in active decision-making and strategic thinking to anticipate demands of the healthcare marketplace and to have demonstrated a commitment to fostering positive relationships among the board, medical staff, community and administration. Our very own John Dalton was named the recipient of this prestigious award in 2017. Following is his acceptance speech.

I grew up on Jersey Avenue in Jersey City; for a Jersey boy, it doesn't get any better than this.

I've worked with so many of healthcare's best and brightest that we'd be here until lunch were I to list them all. So, I'll just thank three who are here today: Steve Jones, Amy Mansue and Kevin Slavin. You epitomize the absolute best of not-for-profit healthcare, and your leadership will be vital in defending access to healthcare as a fundamental human right.

Three women have had a profound positive effect on my life: first, my wife Ann. She's been the wind beneath my wings through 55 years of marriage. We raised three terrific children, and Ann has been at my side through all the challenges we've faced – and there've been a few. Thanks, love, for always being there for me. My mom, Kay Dalton, was born left handed like me, but the nuns forced her to write right handed. When I entered kindergarten at St. Michael's, Jersey City, Mom bravely marched me into the principal's office and told sister: "Don't do to him what the nuns did to me – he's left handed and he's staying that way." Thanks Mom for keeping me in my right mind!

Finally, Sister Mary Magdalen of the Sisters of Charity of St. Elizabeth was our high school English and Religion teacher. She instilled in us both a love of the English language and a simple philosophy to guide us through life. Sister taught us that it doesn't matter how much wealth you amass or how powerful you become; when your time comes to be judged, God will ask you only two questions:

1. *Did you do the best that you could with the skills, talents and abilities I gave you? and*
2. *Did you work to the world a better place for my people?*

Folks, if you can answer "Yes" to both, you'll never be caught short, whether here or hereafter. Thank you again for this incredible honor!

2017 Healthcare Leader Awards

NJHA's Healthcare Leader Awards recognize the significant contributions of individuals to New Jersey's healthcare community. For their exceptional leadership and commitment to hospitals and the patients they serve, NJHA proudly presents the 2017 Healthcare Leader awards to:

Hospital Trustee of the Year

JOHN J. DALTON
Honorary Trustee
Children's Specialized Hospital, RWJBarnabas Health
St. Joseph's Healthcare System

Healthcare System Trustee of the Year

JOSEPH SIMUNOVICH
Co-Chairman
Hackensack Meridian Health Board of Trustees

Healthcare Professional of the Year

VICTOR PARSONNET, MD
Chair of the Institutional Review Board
Medical Director, Pacemaker and Defibrillator Center
Newark Beth Israel Medical Center
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Distinguished Service

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ELIZABETH A. RYAN, ESQ.
President and Chief Executive Officer
New Jersey Hospital Association

HOSPITAL TRUSTEE OF THE YEAR

JOHN J. DALTON
Honorary Trustee
Children's Specialized Hospital, RWJBarnabas Health
St. Joseph's Healthcare System

After more than 45 years in healthcare operations and finance, John Dalton has continued to show unwavering passion for the communities and patients of Children's Specialized Hospital and St. Joseph's Healthcare System.

Through his service, patronage and loyalty he has become and always will be a vital member of the Children's Specialized Hospital and St. Joseph's families. In addition to his outstanding service on the Board of Trustees, he has overcome challenging circumstances with class and grace.

He has served on the Children's Specialized Hospital Board of Trustees since 1986 and has been an honorary trustee since 2005, including a three year term as chairman and multiple terms on the executive board. At the same time, he has served as a member of the Board of Trustees of St. Joseph's Healthcare System since 2003 and previously held the position of vice-chairman and is currently the Strategic Planning Committee chairman.

"John has had a remarkable impact not only on Children's Specialized Hospital, but the healthcare industry as a whole," said Warren E. Moore, President and CEO, Children's Specialized Hospital. "He is determined to make a difference and his compassion, innovation and commitment to the advancement of the healthcare industry is visible to everyone he meets."

"At St. Joseph's Healthcare System, John been a constant force to ensure the healthcare needs of the medically underserved and impoverished are met," said Kevin Slavin, president and CEO of St. Joseph's Healthcare System. "He has selflessly offered his financial expertise to the hospital as we continue to face challenges meeting the unending need for charity care."

Dalton formed Healthcare Business Specialists, Inc. (HBS) in 1986 to provide revenue cycle consulting and accounts receivable management services to healthcare providers, serving as its president and CEO until HBS was acquired in 1992. His service at the Healthcare Financial Management Association (HFMA) includes, but is not limited to, leadership roles in both the national organization and the New Jersey chapter.

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AUDIT TAX ADVISORY

The Essential Elements of CJR

Maria C. Miranda

by Maria C. Miranda, FACHE

Introduction

While the Comprehensive Care for Joint Replacement (CJR) program is positioned as a "test," given the infrastructure being put in place by CMS to run the program, CJR is likely just the start of a larger effort by CMS to implement additional mandatory bundled payment programs. Therefore, it's very important that hospital financial stakeholders become familiar with CJR even if their hospital isn't currently a participant.

Program Summary

The Comprehensive Care for Joint Replacement (CJR) bundled payment model is effective April 1, 2016 and is set to continue through five performance periods ending on December 31, 2020. CMS is implementing this model via its authority under section 1115A of the Social Security Act as modified by Section 3021 of the Affordable Care Act, which established the Center for Medicare and Medicaid Innovation (CMMI). CMMI was created to test new payment and service delivery models with the goals of reducing CMS program expenditures while maintaining or improving outcomes.

The Comprehensive Care for Joint Replacement (CJR) bundled payment model is effective April 1, 2016 and is set to continue through five performance periods ending on December 31, 2020.

CJR will test a new bundled payment model for inpatient lower extremity (i.e. hip and knee) joint replacements.

Unlike voluntary programs such as BPCI, with few exceptions participation in CJR is mandatory for hospitals in 67 selected MSAs.

CJR Episodes

A CJR episode starts with admission of an eligible beneficiary for an LEJR procedure ultimately discharged under one of the following two MS-DRGs:

- MS-DRG 469: Major Joint Replacement or Reattachment of Lower Extremity with MCC
- MS-DRG 470: Major Joint Replacement or Reattachment of Lower Extremity without MCC

CMS refers to these two MS-DRGs as "anchor MS-DRGs."

The episode also includes all related Medicare Part A and Part B care for 90 days after discharge. This includes additional hospital stays, care received at SNFs and other post-acute providers, physician visits, physical therapy, etc. unless the provided service is on a CMS exclusion list.

The day of discharge counts as the first day of the 90 day post-discharge period.

CMS will exclude subsequent unrelated hospital stays from the episode based on MS-DRG. Similarly, CMS will identify unrelated outpatient care based on ICD-9 / ICD-10 code. CMS will update the lists for both exclusion types on an annual basis, at a minimum, during the CJR program. The exclusions will apply to the calculation of both target prices and episode spending.

Target Prices

CMS uses three years of historical data to set target prices. The historical data will be updated every other year during the program. Both hospital-specific and regional data is used. Regional pricing is included in the calculations to provide gainsharing opportunities for hospitals that are already well-performing.

CMS will provide hospitals with a number of target prices for each performance year, segmented by MS-DRG, presence of hip fracture and submission of optional quality data. In addition, since CMS will normalize prices based on various IPPS and OPPS program changes (which go into effect on 10/1 and 1/1 of each calendar year, respectively), CMS will further distinguish target prices for episodes initiated between January 1 and September 30 vs. episodes initiated between October 1 and December 31.

CMS applies a discount factor to the target prices, which is Medicare's portion of the reduced expenditures from the CJR episodes.

Episode Spending

CMS calculates the spending for an episode by summing payments for qualified hospitalizations under MS-DRG 469 and 470 and all subsequent related Part A and Part B care for 90 days post-discharge.

Quality Measures

CMS is implementing a composite quality score to determine eligibility for reconciliation payments and to potentially reduce the discount factor applied to episode spending when determining the amount of repayment or reconciliation payment.

The composite quality score is based on three weighted measures:

- Hospital-level risk-standardized complication rate following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA)
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey
- THA/TKA voluntary patient-reported outcome and limited risk variable data submission

Providers should be working now to proactively identify areas of risk under CJR and put a program in place that measures their ongoing performance.

Reconciling Payments

After each CJR performance year, CMS will perform a retrospective reconciliation of CJR episode spending compared to the target prices by calculating the Net Payment Reconciliation Amount (NPRA). The NPRA is the sum of the amounts above and below the target price for each CJR episode in the performance period.

If the final NPRA is below zero, that amount is paid to the hospital as a "reconciliation payment" as long as the hospital meets a minimum composite quality score. If the NPRA is above zero, that amount is owed to CMS by the hospital as a "repayment amount."

Hospitals will not be responsible for any repayment amount due for the first performance year, but may earn reconciliation payments for all performance years.

Data Sharing

CMS will provide detailed and summary claim and payment data related to CJR episodes to participant hospitals so that they may better understand their target price calculations and operational performance and identify areas for improvement.

Financial Agreements with Other Providers

Since CMS considers care coordination critical for successful LEJR outcomes, they are allowing CJR hospitals to establish risk-sharing and gain-sharing relationships ("sharing arrangements" described in "collaborator agreements") with other providers ("CJR collaborators").

When risk-sharing payments are made to a hospital by a CJR collaborator, CMS refers to the payment as an "alignment payment." A hospital that shares a reconciliation payment with a CJR collaborator makes a "gainsharing payment."

Waivers

In order to make the implementation and operation of the CJR program more efficient and potentially more effective, CMS is introducing a number of program waivers related to home health visits, telehealth and the SNF 3-Day Rule.

Conclusion

Providers should be working now to proactively identify areas of risk under CJR and put a program in place that measures their ongoing performance.

A special report is available at besler.com/cjr that further explains how CJR works and expands on the responsibilities of participating providers.

About the Author

Maria Miranda is the Director of Reimbursement Services. Maria has 25 years of progressive experience in healthcare administration and is a longstanding member of the Health Care Financial Management Association and a Fellow of the American College of Health Care Executives. Maria holds a Bachelor of Science degree in Health Care Administration from St. John's University and a Master of Public Administration in Health Services from Fairleigh Dickinson University. Maria can be reached at mmiranda@besler.com.

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•Focus on Finance•

IRS Releases 2016 Form 990, Schedule H

John A. Smith, Jr.

By John A. Smith, Jr.

Q. How has the Internal Revenue Service ("IRS") revised the 2016 Form 990, Schedule H, Hospitals to incorporate related provisions outlined in the Internal Revenue Code ("IRC") §501(r) final regulations that were effective for taxable years beginning after December 29, 2015?

A. The Affordable Care Act ("ACA"), signed into law by President Obama on March 23, 2010, introduced IRC §501(r) which includes four new requirements that tax-exempt hospital facilities are required to comply with related to a tax-exempt hospital facility's:

- 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)).

Tax-exempt hospital facilities were required to be compliant with the community health need assessment for taxable years beginning after March 23, 2012. The final regulations under IRC §501(r) apply to tax-exempt hospital facility's taxable years beginning after December 29, 2015. All tax-exempt hospital facilities were given at least one year to become fully compliant with the final regulations with regards to IRC §501(r)(4), IRC §501(r)(5) and IRC §501(r)(6). For example:

- Tax-exempt hospital facilities with a December 31st calendar year-end had until January 1, 2016 to be fully compliant;
- Tax-exempt hospital facilities with a June 30th fiscal year-end had until July 1, 2016; and
- Tax-exempt hospital facilities with a September 30th fiscal year-end had until October 1, 2016.

2016 Schedule H

IRC §501(r)(3) requires a tax-exempt hospital facility to conduct a community health needs assessment ("CHNA") once every three years and to adopt a written implementation plan/strategy addressing the significant needs identified in the CHNA. The IRS revised Schedule H, Part V, Line 3i to allow a hospital facility to describe the impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA. Previously, Line 3i allowed a hospital facility to describe whether or not there were any information gaps that limited the hospital facility's ability to assess the community's health needs.

IRC §501(r)(4) requires tax-exempt hospital facilities to widely publicize their Financial Assistance Policy ("FAP") within the community served. The IRS revised Part V, Section B, Line 16 to simply ask if the tax-exempt hospital facility widely publicized its FAP in the community served by the hospital facility. Formerly, the question asked if the hospital facility included measures to publicize the FAP in the community served.

The IRS further revised Part V, Section B, Line 16 to allow tax-exempt hospital facilities to indicate how their FAP was widely publicized during the tax year. In doing so, the IRS added a new checkbox on Part V, Section B, Line 16g to indicate whether or not the tax-exempt hospital facility notified individuals about the FAP by being offered a paper copy of the plain language summary of the FAP ("PLS"), by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention.

Under the final regulations, a hospital facility's FAP, FAP application form, and PLS must be made available in English and in the primary language of any population which constitutes the lesser of 1,000 individuals or 5 percent of the community served by the hospital facility; Limited English Proficiency ("LEP"). The IRS revised the 2016 Schedule H, with the addition of Part V, Section B, Line 16i to allow a tax-exempt hospital facility to indicate whether or not it was in compliance with this requirement.

IRC §501(r)(5) requires tax-exempt hospital facilities to limit amounts charged for emergency or other medically neces-

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Laughing at Labels

by Jan McInnis

Jan McInnis

As a keynote speaker and a comedian, life has not always been Hiltons and Marriotts. I've found myself in some other unusual places!

So I'm sitting in a factory surrounded by women from other countries who are fast at work on their sewing machines making clothing for burlesque dancers (not a joke!). I couldn't talk with these women due to the language barrier, but I'm sure the joke was on me as they wondered what a tall, gawky-looking girl like me was doing there. They probably figured I was the bottom of the barrel when it comes to dancers – maybe a dollar store dancer or something.

That was many years ago, and I happened to be there not because I was looking for new outfits for my comedy career, but because I had a day off between comedy club gigs and I was staying with a comedian friend who also had a lucrative burlesque clothing line going on the side. I could hang out in his factory and use the internet all day for free. (Hey, those were the dial-up days and I needed a phone line!)

I love my job as a comedian and keynote speaker not just because of all the cool people I meet and the interesting industries that I get to learn about, but also because I find myself in all sorts of unique situations. Comedy encourages strange bedfellows, and as such, I think one of the most useful skills we comedians have learned is not to judge and label these situations. We just go with the flow!

Going with the flow isn't so easy, but in the long run it's more productive than slapping a label on something. Once you determine that something is bad, or good, or weird, or inappropriate, then the label colors how you feel about it and how you react to it. Many times, these labels tend to hinder rather than help the situation. You can't sit in a burlesque clothing factory and worry that you might have taken a wrong path in your career: you have to just enjoy the moment.

I've done comedy shows on cruise ships, which are a lot of fun, but they can be scary also. Not because you're in the middle of the ocean and if the ship loses power you might have to turn your trashcan into a toilet. No, it's because there's always someone (or even a few people) in the audience, usually sitting in the front row, whose outfit includes jewelry, a dinner jacket or dress. . . *and an oxygen tank*. Oh, and they're usually asleep. . . at the 6:00 p.m. show. I typically estimate this person's age at 130, give or take a decade. On the other hand, sometimes I do shows for colleges, and I look to be 130 to them! But if I start to label that these situations are not going to work, and the audience is too old or too young for me, then guess what? My show tanks and I start wishing for a loss of power so that I can get off stage. Sometimes labels aren't all that helpful.

I once had a job in which my coworkers thought I was mentally challenged. I'm neither joking nor am I making fun of those who are, but I was put in that category and it was weird. Right out of college I was temping for a major corporation, and they had me working with a guy I'll call Bob, who was mentally challenged. We worked in the computer room delivering computer printouts, because it was back in the day when no one had their own printer and the massive paper printouts came from a computer the size of an IMAX movie screen. (Yeah, I'm THAT old!) I didn't chat much with the people I was delivering these printouts to, other than to say "hi" and "how are you", and they'd say "hi", "I'm fine" and "nice sweater." (I always wore these cool sweaters. Okay, cool for the 80s.) I was more shy than I am now, and I thought these people were very important (they had their own computers, for gosh sakes) so I was intimidated to talk with them and take up their time. And because I was so quiet, and I worked with Bob, the looks I got from these people were compassionate looks, and caring looks, and looks that just let me know that *they* knew I was different. . . like my "boss" Bob.

About two months into my computer-printout-delivery career, I was walking down the hall to the cafeteria and one of the computer guys asked if I wanted to join his group for lunch. I'm pretty sure he thought he was being kind and doing me a favor. The lunch table chatter turned to colleges and who went where. I chimed in that I had just graduated from Virginia Tech. You could have heard a pin drop, aside from one guy who actually blurted out "But we thought you were . . ." before catching himself. I explained that I was temping and they had me working with Bob. In an instant I felt the energy shift and the label these people had given me change.

In my keynote, *Finding the Funny in Change*, I reference Cesar Millan, the *Dog Whisperer*, because he's a great example of watching the way you label things. He talks about using your personal energy to change the behavior of dogs, and that you should watch the thoughts that go through your head because they influence the dog's behavior! Cesar says that "you must change the conversation in your head" and "speak from

the inside out." He understands the power of a label. He'll even strongly suggest that someone change their dog's name, if it is something like "Killer" and the dog is vicious.

We try to prepare ourselves with labels about the past, the present and the future, but many times we are way off. Remember the millennium? All of our computers were supposed to crash at midnight. That didn't happen until a couple years ago when Microsoft came out with Vista! Remember when eggs were bad and asbestos was good?

According to the book Stumbling on Happiness the average person spends 12% of their waking hours thinking about the future, and I bet we're labeling most of it. Instead, why not just take it easy on the labels and enjoy the ride? Even if it takes you to a burlesque clothing factory.

About the author

Comedian and keynote speaker Jan McInnis has shared her customized humor keynotes with thousands of associations and corporations. She is also the author of "Finding the Funny FAST; How To Create Quick Humor To Connect With Clients, Coworkers And Crowds," and "Convention Comedian: Stories and Wisdom From Two Decades of Chicken Dinners and Comedy Clubs." Jan was featured in the Wall Street Journal, the Washington Post, and the Huffington Post for her clean humor, and she can be reached at Jan@theworklady.com, www.TheWorkLady.com. From a recent client: "Jan McInnis took the time to learn about our company and delivered jokes tailored to our audience. Jan's comedic performance is universal which makes her a great choice for a variety of events. We have received numerous compliments from the attendees and would highly recommend her."

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sary care provided to individuals eligible for assistance under its FAP to not more than the amounts generally billed to individuals who have insurance covering such care. The IRS revised the options under Part V, Section B, Line 22 to indicate how the tax-exempt hospital determined, during the tax year, the maximum amounts that can be charged to FAP-Eligible individuals for emergency or other medically necessary care as follows:

- Line 22a - The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period;
- Line 22b - The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-motn period;
- Line 22c - The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a 12-month period; or
- Line 22d - The Hospital facility used a prospective Medicare or Medicaid method.

IRC §501(r)(6) requires a tax-exempt hospital facility to forego extraordinary collection actions ("ECAs") before making reasonable efforts to determine an individual's eligibility under the tax-exempt hospital facility's FAP.

Part V, Section B, Lines 18 and 19 which address actions that may be taken by a hospital facility under its FAP and actions that have been taken by the hospital facility during the tax year before making reasonable efforts to determine an individual's FAP-eligibility have both been revised. A new option has been added under both questions; Line 18c and Line 19c, "Deferring, denying or requiring payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP."

The IRS revised the options under Part V, Section B, Line 20 as follows to provide the tax-exempt hospital facility the opportunity to indicate which efforts the tax-exempt hospital facility or other authorized party made before initiating any of the following actions:

- Provided a written notice about upcoming ECAs and a plain language summary of the FAP at least 30 days before initiating those ECAs;
- Made a reasonable effort to orally notify individuals about the FAP and FAP application process;
- Processed incomplete and complete FAP application; or
- Made presumptive eligibility determinations.

Conclusion

Other than the revisions to the Schedule H in Part V, Section B which address and conform to the final IRC §501(r) regulations, the 2016 Schedule H contains no other significant changes. The IRS revised and updated the 2016 Schedule H to expand the reporting requirements for tax-exempt hospital facilities which are required to report on their compliance with IRC §501(r). It is important to note that the 2016 Schedule H instructions have also been updated to conform to and explain the changes made to the Schedule H itself and to more closely reflect the IRC §501(r) final regulations.

When completing the 2016 Schedule H, tax-exempt hospital facilities should ensure that their Schedule H accurately reflects their compliance with the final regulations.

About the Author

John A. Smith, Jr., is a Supervisor at WithumSmith+Brown, Certified Public Accountants and Consultants, and is a member of the firm's Healthcare Services Group. John can be reached at jsmith@withum.com.

FDA Oversight of Medical Devices Broadened To Include Cybersecurity of Device Software

Jean W. Frydman

by Jean W. Frydman

The FDA now regulates the software of medical monitoring devices as well as the security of the information captured and saved by such software. As a result, this software must first be assessed to determine if it qualifies as a separate device and, if it does, for its vulnerability to a breach.

By their nature, cybersecurity threats are constantly evolving and taking on new forms, so it is unlikely that the FDA could ever craft a successful one-size-fits-all approach.

Once it is determined that a piece of software is a standalone medical device, a separate submission is required to the FDA for clearance to market. That submission must contain an assessment of the impact on functionality and on patients and the likelihood of the threat and the vulnerability of being breached. Risk levels and mitigation strategies must be thought out to assess the residual risk and criteria for risk acceptance.

The FDA issued guidance for the industry in October 2014 on the controls needed to assure medical device cybersecurity and to maintain medical device functionality and safety.

The FDA's concerns are not the same for all software. Primarily, the agency mandates adherence to 21 CFR 820.20(g), which addresses the design controls of the quality system regulations. The extent to which security controls are needed depends on the device's intended use, the presence and intent of its electronic cybersecurity vulnerabilities, the likelihood that a vulnerability will be exploited and the probable risk of patient harm due to a cybersecurity breach. On the other hand, the controls should not unreasonably hinder access to a device that is designed to be used during an emergency.

Controls should include limited access to trusted users only with the necessary features to assure the limited access and ensure trusted content and the transfer of secure data to and from the device.

Features should be implemented that allow for security compromises to be detected, recognized, logged, timed and acted upon during normal use. There should be information available to the end user concerning appropriate actions to take upon detection of a cybersecurity event. The device should have features that protect critical functionality even when its cybersecurity has been compromised. There must also be methods for retention and recovery of device configuration by an authenticated privileged user.

The FDA recommends you submit the following information in your premarket submission:

- Hazard analysis, including a specific list of all cybersecurity risks that were considered in the design of the device and a specific list and justification for all cybersecurity controls that were established for the device.
- Traceability matrix that links your actual cybersecurity controls to the cybersecurity risks that were considered.
- Summary describing the plan for providing validated software updates and patches as needed throughout the lifecycle of the medical device to continue to assure its safety and effectiveness.
- Summary describing controls that are in place to assure that the medical device software will maintain its integrity from the point of origin to the point at which that device leaves the control of the manufacturer.
- Device instruction for use and product specifications related to recommended cybersecurity controls appropriate for the intended use environment (e.g. anti-virus software, use of firewall).

There are several recognized standards you can follow to help you design the medical device to have the controls the agency is requiring.

It is important to note that not all software and apps will qualify as separate medical devices. The FDA has chosen not to assert its enforcement power over those that do not meet the definition of a medical device or pose only a low risk.

For more detail information or to determine if the FDA has jurisdiction over your software or app, contact me.

About the author

Jean W. Frydman is a Partner in the Princeton, NJ office of Fox Rothschild. A former general counsel for multinational pharma-

ceutical companies and a multinational retail dietary supplement company, Jean is an experienced health care attorney at the national law firm of Fox Rothschild LLP. Having spent more than 30 years in-house at major multinational pharmaceutical companies and a major dietary supplement company, she possesses an in-depth knowledge of food and drug law and the regulatory and compliance issues facing clients in the pharmaceutical, medical device and dietary supplement industries. Jean has extensive experience in drug, medical device and dietary supplement promotional review and advises senior management on new Food and Drug Administration (FDA) rules, proactive submissions to the FDA, Current Good Manufacturing Practice (cGMP) compliance and other significant enforcement issues. Jean can be reached at jfrydman@foxrothschild.com.

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Medicaid Access: What Happens Next?

by Theresa Edelstein, MPH, LNHA, and Colleen Picklo

Theresa Edelstein

It is a known fact that the current Administration is committed to reforming healthcare. It has also become clear from the release of the American Health Care Act (AHCA) that reform will include some of the greatest changes to the Medicaid program since its inception more than 50 years ago.

The AHCA proposes moving Medicaid from open-ended federal funding of costs at a specific federal matching amount to capped funding on a percapita basis. Provisions in the AHCA would also impact eligibility requirements, presumptive eligibility determinations and covered benefits.

Because of the magnitude of these proposed changes, it is imperative that states understand the ongoing concerns surrounding access issues for Medicaid beneficiaries to prepare to address the new challenges that these changes will cause.

Almost since the inception of the Medicaid program there have been questions surrounding the program's value. Specifically, the key question has been whether access to coverage equates with access to care, and whether that access leads to improvements in individuals' health status. Because of this, there have been numerous studies over the years that have tried to answer these questions.

It is a known fact that the current Administration is committed to reforming healthcare. It has also become clear from the release of the American Health Care Act (AHCA) that reform will include some of the greatest changes to the Medicaid program since its inception more than 50 years ago.

History

The Medicaid program was established by law in 1965 in order to provide medical assistance to the most vulnerable. Medicaid is funded by federal and state budgets and currently provides coverage to more than 74 million of the nation's most needy citizens - predominately children and the elderly.

Much of the recent growth in the program is due to the 2010 Patient Protection and Affordable Care Act (ACA) which allowed states to expand Medicaid coverage to childless adults making up to 138 percent of the federal poverty level. In New Jersey, Medicaid now covers more than 1.7 million residents, over 566,000 of whom are newly covered as a result of the ACA.

In tandem with expansion came a broadening of states' usage of a Medicaid managed care model to cover certain individuals and services. In 1995, New Jersey moved certain services for children and adults into a managed care model. In 2011, New Jersey began a transition of individuals needing managed long term care supports and services (MLTSS) to managed care. In July 2014, New Jersey moved nursing home, assisted living and residential settings for traumatic brain injury into managed care under the MLTSS program. Behavioral healthcare, except for those served by MLTSS, is the only significant "carve out" from managed Medicaid in New Jersey. Currently, 91 percent of Medicaid beneficiaries now receive care through a managed care organization (MCO).

The intersection of these programmatic changes led to further study by healthcare stakeholders to ensure that the newly covered beneficiaries under Medicaid expansion had access to care and also that the MCO model wasn't managing costs by limiting access.

Access – The ACA Data

A Kaiser Family Foundation (KFF) issue brief from 2013 - *What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care? Setting the Record Straight on the Evidence* – shared insights from a literature review that provided clear findings on the benefits of Medicaid as it relates to access to providers and coverage.

Specifically, the findings indicated that not only did Medicaid lead to improved access to care and use of recommended

care for beneficiaries relative to the uninsured, research also provided evidence that broader eligibility for Medicaid at the state level is associated with significant reductions in both child and adult mortality.

Also, an issue brief from the Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation issued in 2017 found that Medicaid expansion had a direct effect on reducing the number of uninsured adults. In fact, expansion states were found to have realized a 9.2 percentage reduction in the number of uninsured adults nationally and the number of low-income adults reporting unmet healthcare needs decreased by 10.5 percentage points.

This is particularly noteworthy because the KFF issue brief also indicated that interruptions in Medicaid coverage have been shown to lead to greater emergency department use as well as significant increases in hospitalizations for conditions that can be managed on an ambulatory basis.

Access – The Managed Care View

Conversely, while the research clearly indicates the value of having Medicaid coverage versus no insurance coverage, questions remain regarding provider access under a managed care model.

In 2012 the Office of the Inspector General (OIG) released a study, *State Standards for Access To Care in Medicaid Managed Care,* OEI-02-11-00320, that provided an overview of states' network adequacy requirements which are intended to ensure access to care. The study found that there is a great deal of variance in the standards that states develop; not all states have standards related to specific provider types and all states had different strategies for assessing compliance with adequacy requirements and the enforcement of the standards.

A companion study from OIG, *Access to Care: Provider Availability In Medicaid Managed Care,* OEI-02-13-00670, published in 2014, found that there was a great deal of inaccuracy in Medicaid MCOs provider directories which led to serious delays in access to care.

...while the research clearly indicates the value of having Medicaid coverage versus no insurance coverage, questions remain regarding provider access under a managed care model.

In fact, in New Jersey studies found that not only are doctors the least likely to accept new Medicaid patients (only 38.7 percent of Garden State physicians indicated they were accepting new patients in 2013) but that an investigation of the insurance company lists of participating providers were inaccurate or out-of-date.

In New Jersey, Medicaid now covers more than 1.7 million residents, over 566,000 of whom are newly covered as a result of the ACA.

There are a wide array of reasons that affect a beneficiary's access to care and services. For example, New Jersey doctors are the least likely to accept new Medicaid patients, while it is also among the states with the lowest physician payment rates, well below that of neighboring states.

Other reasons include MCO contracting requirements – both those that are subject to by state law and those that they pass on to providers -- physician shortages, and a state's need to balance enforcement with an MCO's willingness to participate.

Given these already existing challenges, the impact of future changes to the Medicaid program needs to be carefully considered from an access perspective.

The Future

As the Trump Administration engages in efforts to reform healthcare, it becomes increasingly clear that a large part of these efforts will focus on Medicaid reform.

With the release of the AHCA, it is possible to tease out some of the Administration's intentions for the Medicaid program. For example, several of the provisions in the AHCA include, among other changes: implementing a per capita cap; eliminating the essential health benefit package; and shortening the timeframes and increasing the frequency in which beneficiaries must reapply for eligibility.

Under a per capita cap, states would receive capped funding for five enrollment groups (elderly, blind and disabled, children, expansion adults and other adults) based on the number of beneficiaries and the 2016 level of medical expenditures.

Additionally, states would be responsible for 100 percent of any costs in excess of the per capita cap, regardless of the reason for the excess. States can experience unanticipated costs for many reasons including demographic changes, healthcare cost growth due to a new drug or a public health outbreak like Zika virus. States that exceed their per capita allotment would be penalized by reduced federal payments in the following year.

Because most states must have balanced budgets, requiring states to pay a greater portion of Medicaid will almost certainly result in decreases to provider reimbursements, which in turn

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will lead to more providers being unwilling to accept Medicaid beneficiaries. This will have a detrimental impact on access to primary care and drive costs up further because individuals will seek more of their care in higher costs settings, most notably the emergency room or hospital.

The bill also eliminates ACA requirements that the benefit package provided to Medicaid expansion beneficiaries must be equivalent to the essential health benefits offered in individual and small group health insurance plans.

This will have a direct effect on the preventive services that a beneficiary receives as well as putting coverage for substance abuse and mental healthcare services at risk. Consequently, this will have an impact on the use of hospital care, most likely in the form of increased emergency room use but also in the form of hospitalization as a result of not having appropriate management of chronic conditions.

New Jersey studies found that not only are doctors the least likely to accept new Medicaid patients (only 38.7 percent of Garden State physicians indicated they were accepting new patients in 2013) but that an investigation of the insurance company lists of participating providers were inaccurate or out-of-date.

The eligibility requirements under the AHCA would mean that enrollees must apply to have their eligibility re-determined more frequently. While initially this may not appear to have an impact on access, the increased frequency of applying could result in missed deadlines. The current annual redetermination timeframe already results in delays and lapses in coverage. This concern, in tandem with the fact that enrollees can be locked out for not having continuous coverage, will most certainly lead to individuals losing coverage.

Conclusion

It remains to be seen what form the AHCA will take upon enactment, if it does indeed get passed by Congress. However, it is imperative that states recognize that healthcare reform efforts go well beyond repealing the private insurance market reforms. In fact, the largest impact, at least initially, appears to be to the Medicaid program. The impact of these changes could be devastating, not only to the beneficiaries that require care but the healthcare system as a whole, which relies upon funding to ensure access to care for the most vulnerable among us.

That is why it is imperative that the Medicaid funding model must be flexible enough to respond to changing dynamics. Absent that, any perceived savings to the Medicaid program will arguably be as a result of the loss of access for millions of individuals to the country's largest safety net.

About the authors

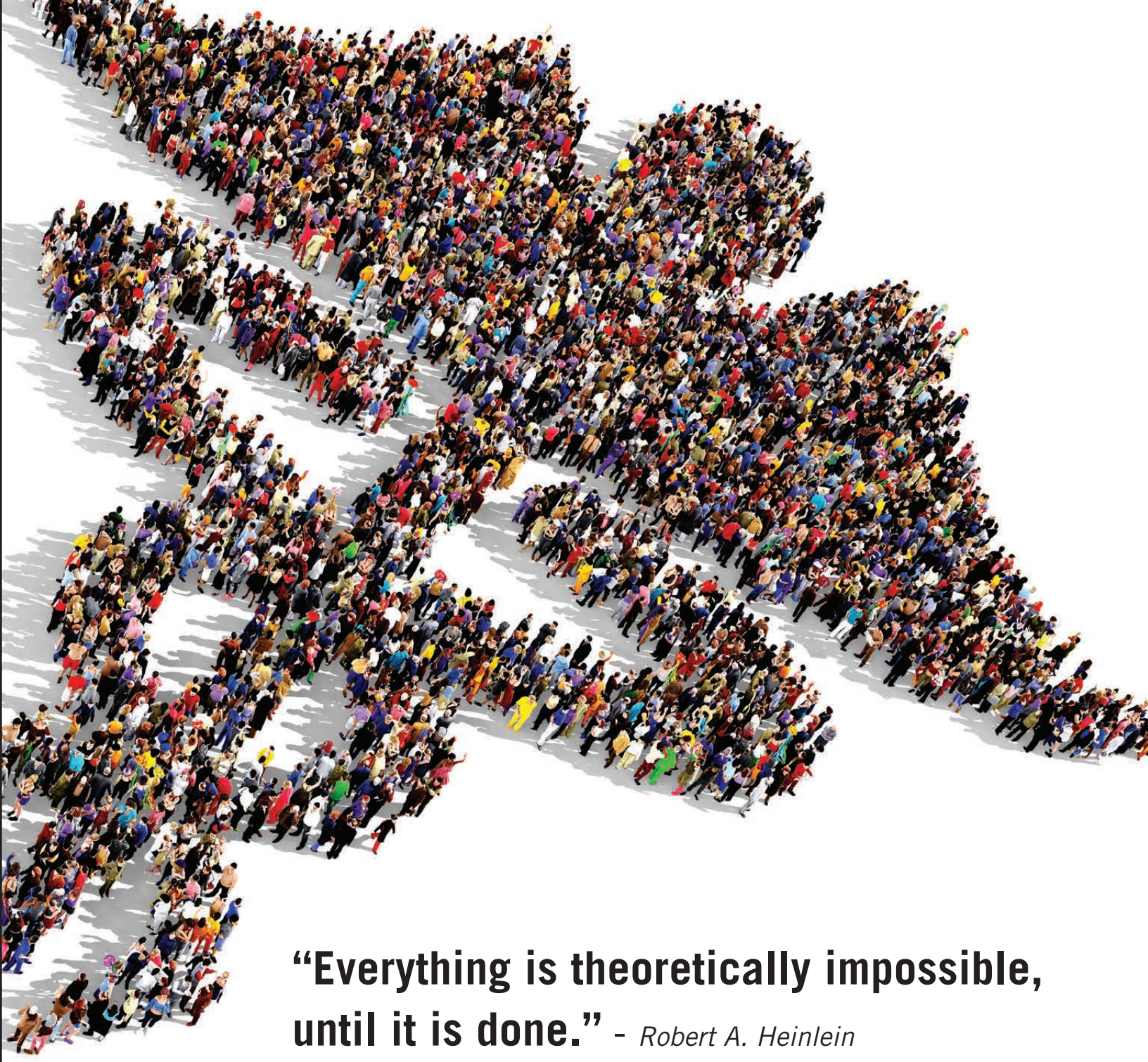
Ms. Edelstein is Vice President of Post-Acute Care Policy & Special Initiatives at the New Jersey Hospital Association where she has been for 19 years. She directs the policy, regulatory, education and membership services activities of the Association as they relate to post-acute care. In addition, Theresa coordinates policy work related to insurance and managed care. Earlier in her career, Theresa worked as a licensed nursing home administrator in New Jersey and New York.

Theresa has her Masters in Public Health from Columbia University, School of Public Health and her Bachelor of Science from Georgetown University. She has presented and published nationally and internationally on topics related to post-acute care services, quality and policy.

Colleen Picklo is the Deputy Director of Managed Care and Insurance at the New Jersey Hospital Association. In this role Colleen is responsible for analyzing insurance based regulations and legislation to gauge the policy implications for NJHA's membership, and participates in the association's advocacy efforts related to legislative and regulatory initiatives.

Colleen also provides member assistance related to current regulatory and legislative compliance by managed care companies and by facilitating outreach to managed care companies or regulatory agencies.

Colleen has been with the Association for 20 years.



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hfma new jersey chapter
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May 9, 2017

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