NEWSCAST

Metro NY HFMA | Summer 2020 | Volume 50, Issue 2

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hfma Your Challenge. *Our Mission.* 20-21

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PRESIDENT'S MESSAGE

Happy Summer! I am both honored and excited to serve as the 2020-2021 Metro NY Chapter President and consider this a great privilege to lead one of the largest chapters in the country. I have been involved with the chapter for the past 18 years and am so fortunate to have had the opportunity to learn from the past presidents who have gone before me and I know that I can rely on them for advice, guidance and support throughout the year.

As I begin the year I would like to start off by thanking Diane McCarthy for her dedication, hard work and commitment to the chapter. Diane had a tremendous year and oversaw the launch of our evening educational programs lead by Sean Smith, VP of Education, and Andrew Weingartner. This series of evening programs was well received and added a new twist to the standard day seminars. The programs were well attended and the feedback was very positive. Diane, Sean and Andrew also had many great programs planned for March-May to round out the education year, including an outstanding Annual Institute under the leadership of Shivam Sohan. I recognize all the hard work and effort that was put forth by our committee members in planning these events and hope that we can hold these programs in 2020-2021. Thank you Diane and Congratulations on a very successful year!

While I originally thought this year might be a challenge, my view has changed. I now see an opportunity to reinvent how we deliver educational programs. We will continue the HFMA mission, Leading the financial management of health care, by bringing timely, relevant and robust educational programs. Along with Cathy Ekbom and the General Education team, Leah Amante, Alyson Belz and Robert Braun, we've begun our immediate chapter planning dubbed HFMA Metro NY - 2020 Vision, a 6 month work plan of virtual webinars, focus groups, training and a Knowledge is Power program all being held in 2020.

We kicked off the May 1st education year with a collaborative program with the Hospital Association of New York State (HANYS) HANYS Update – COVID 19 Revenue Cycle – Managed Care Issues. Victoria Aufiero and Jeff Gold of HANYS presented valuable updates on state regulations enacted during the pandemic and they graciously responded to a litany of questions from the attendees. This webinar drew approximately 200 NYS revenue cycle professionals, and we look forward to a follow-up program and even more collaborations with HANYS.

Beginning July 22nd we start our Webinar Wednesday programs with a 4 part series, Response to COVID 19. This lunch and learn includes segments from Finance, Revenue Cycle, Compliance and Technology. Look for future Webinar Wednesday programs in our weekly email update or check the chapter website; http://www.hfmametrony.org.

Throughout my HFMA career I have served as Chair of Managed Care, General Education and as Vice President of Education, and throughout my tenure the hardest challenge has been determining what topics

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would be attractive to our members, what topics and issues they want to learn about. To ensure that we are bringing forth programs that ensure we meet the needs of our members, we held our first focus group with Metro area Revenue Cycle leaders. Focus groups enable us to gain insight on the programs that meet the rapid changes within our industry. The healthcare industry has been evolving with advancements in technology both clinically and operationally before the pandemic, and even more so as we have witnessed the rapid-fire changes made in response to the pandemic. We must continue to answer and fulfill the need of providing relevant and robust educational programs and I am certain that we will! We recently made the decision to survey our membership to see what programs and topics we can offer throughout the year. This will be a quick survey so please take a minute to respond when you receive our email.

While we look to do virtual programs in the immediate future, we will remain flexible to convert these programs to in-person events and vice versa if needed. As I said in my speech during the Annual Business Meeting, this is not my year, this is our year! And I know how truly fortunate I am to have Sean, Cathy, Tracey and Andrew as fellow officers. I know I can count on each of them to continue the HFMA Metro NY tradition of quality programs and social networking events.

To our Corporate Sponsors, we cannot serve the HFMA mission without you. As we move forward in our virtual programming we will be relying on you even more for speakers and program ideas. We will find creative ways to ensure that you are afforded valuable "face-time" to connect with our membership and we look to hosting networking events as soon as we are permitted to do so safely and responsibly.

I am anxious to see my fellow Officers, Executives, Board of Directors, volunteers, members and Corporate Sponsors. I love the comradery of being together! Although Zoom is a wonderful tool there is nothing like the real thing! Sharing a meal, a story, a laugh, face to face.

So until we meet again please stay well and enjoy the summer sunshine and warm weather, and as always thank you for your support of the HFMA Metro NY Chapter.

Donna

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EDITOR'S MESSAGE

The Summer Edition of Newscast signifies the start of HFMA's new year. With each year we bid a fond farewell to some old friends and colleagues and a robust hello to new ones. We express a sincere thank you to the Immediate Past President, Diane R. McCarthy, and welcome, the new President, Donna M. Skura. We usually get to do this in person with handshakes, and hugs. This year, thanks to Coronavirus, it was through a virtual business meeting.

We highlight how well the Chapter performed under Diane's leadership by acknowledging the receipt of the Silver Award of Excellence for Educational Quality, the Bronze Award of Excellence for Certification as well as three (3) Chapter Yergers and three (3) Regional Awards. We hoped that we would have the opportunity to honor Diane and celebrate her presidency at the Annual Past President Dinner Dance which was scheduled to be held at the TWA Hotel on November 7, 2020. Unfortunately this will be postponed to a later date to insure we can all gather safely. Please join me in hoping that New York will continue to see its COVID rate hold steady or even better, continuing to decline.

In welcoming our new President, Donna, we look towards the National Chairperson's theme, "Your Challenge. Our Mission. " Some of the hardest decisions in life involve figuring out when to persist and persevere, and when to let go and start over fresh. Recognizing the year 2020 has brought and continues to bring significant disruption and new challenges to healthcare by way of a global pandemic, Donna brings to our Chapter the promise to seize the opportunity to reinvent how we deliver value and education to our members rather than being discouraged by the impediments COVID-19 has caused and continues to cause.

In doing my part for the Chapter, I will continue to work with our Board and Chapter members to provide a Newscast that not only provides educational content, but a positive perspective of perseverance through a global pandemic. One of my favorite quotes is contained in our new addition Scenes across MetroNY and clearly is relevant to the situation we all currently find ourselves in. "Human beings can get used to virtually anything, given plenty of time and no choice in the matter whatsoever." To persevere we must adapt – adapting is what we all have been doing these past 5 months and will continue to do for the foreseeable future. We will all be better served if we reflect, learn, move on, and don't look back!

As a special note, I'd like to acknowledge Jaime Derkash, a summer intern at Miller & Milone, P.C. and Jessica Daly for their assistance with this issue. Enjoy the rest of the summer,

Alicia

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Metro NY HFMA Newscast Summer Schedule

Electronic Publication Date	**10/30/20**
Article Deadline for Receipt by Editor	**9/25/20**

2020-2021 CORPORATE SPONSORS

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IMPORTANT DATES

Upcoming Webinars

Sept 2, 2020 3:00 pm	EQUIPMENT SHARING: A NEW WAY FOR FINANCE LEADERS TO SAVE CAPITAL DOLLARS Hosted by HFMA National
Sept 10, 2020 3:00 pm	2021 PROPOSED RULE CHANGES TO OPPS AND ASC PAYMENT SYSTEM Hosted by HFMA National
Sept 16, 2020 12:00 pm	ACHIEVING WORKING CAPITAL EFFICIENCY AND CASH MANAGEMENT Hosted by HFMA National
Sept 16, 2020 1:00 pm	DRAFTING EFFECTIVE APPEALS Hosted by HFMA Region 2
Sept 23, 2020 1:00 pm	RECOUPMENTS Hosted by HFMA Region 2
Sept 24, 2020 3:00 pm	2021 INPATIENT PROSPECTIVE PAYMENT SYSTEMS (IPPS) FINAL REGULATIONS Hosted by HFMA National
Sept 30 & Oct 2, 2020	DIGITAL REVENUE CYCLE CONFERENCE 2020 Hosted by HFMA National
Oct 14-16, 2020	REGION 2 ANNUAL FALL INSTITUTE: DESIGNING HEALTHCARE FOR THE FUTURE (DIGITAL CONFERENCE) Hosted by HFMA Region 2

Events

TBD	PAST PRESIDENTS DINNER DANCE	TWA Hotel

HFMA Seminars provide timely, in-depth strategies and metrics to help you keep pace with the healthcare finance topics you care about the most. View all upcoming HFMA Seminars and register at www.hfma.org/seminars.

The Metropolitan New York Chapter of HFMA Proudly Welcomes the Following New Members!

By Robin Ziegler, Membership Committee Chair

MetroNY HFMA is pleased to welcome the following new members to our Chapter. We ask our current membership to roll out the red carpet to these new members and help them see for themselves the benefits of HFMA membership. Encourage them to attend seminars and other Chapter events. We ask these new members to consider joining a Committee to not only help the Chapter accomplish its work, but to expand their networks of top notch personal and professional relationships. See the list of MetroNY HFMA Committee Chairs, along with their contact information, listed in this eNewsletter.

APRIL 2020

ANNA VELKIN
ArchCare

JULISSA GOMEZ

SARAH KHAN

CYNTHIA HOLMES

NICHOLAS PAGONIS

VANESSA BUTCHER

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KENNETH SCHWARTZ
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CARL LUND
Catholic Health Services of Long Island

STEPHEN SUOZZI
Perlmutter Cancer Center

ERIKA VILOMAR, CRCR
Community Care Companions

RAJDEEP BRAR
Northwell Health

MAY 2020

DANIEL GOLDEN
New York Presbyterian Hospital

SHIVANI CHOPRA

ALEXANDRA WRIGHT

KAREN CHASE
Accuity Delivery Systems, LLC

BRANDON THEODULE
South Oaks Hospital Northwell Health

KHALILAH HOGAN
Lutheran Social Services

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AMANPREET SINGH

ALICIA BACCHUS
Mount Sinai South Nassau

RASHIDA MCPHERSON

KAYESHA HAMILTON

SHAMEKA SHOEMAKER

JUNE 2020

JENNIFER GRAVES
Commerce Bank

IVAN BUDHRAM, CHFP, CRCR

CRISTIE GOLSON
Family Service League

NYSIA TORRES
Montefiore Medical Center

MATTHEW SHUMWAY
United Health Care

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JOSEPH MANORY
Alvarez & Marsal
Healthcare Industry Group

JOSE GEREZ
Flushing Hospital

EMRE OZELKAN
NYU Winthrop Hospital

CRYSTAL PERSAD
Northwell Health

DEVON JUDGE
Mazars USA

MATTHEW BREGMAN
Mount Sinai Health System

BILLY ROONEY
Deloitte Consulting LLP

The Annual Business Meeting for The Metropolitan New York Chapter of HFMA

Wednesday, May 27, 2020
6:30PM - 7:00PM

"You can't change the direction of the wind – but you adjust your sails."

Due to the continued COVID-19 crisis, our chapter will be having a Virtual ABM this year.

While we will miss the personal touch that this event has always offered, it is still an important event for all of our members. It is an opportunity to thank our corporate sponsors as well as recognizing those who have earned HFMA awards and worked to achieve certification status this past year.

Please join us in congratulating them, as well as installing our incoming officers and board members for the 2020/2021 year. The year ahead will be offering challenges as well as opportunities for them, and I have complete confidence that all of them are ready to bring the Metro New York Chapter to new levels of excellence.

While you will not be able to shake their hands in person, please be sure to join us for the Virtual ABM and give them all the support they deserve. I look forward to "seeing" you at the meeting.

Diane McCarthy, CPA/FHFMA

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metropolitan new york chapter

A Message from Diane McCarthy
HFMA Metro NY Chapter

HFMA recognizes that its strength lies in volunteers, who contribute their time, ideas, and energy to serve the healthcare industry, their profession, and one another. Active participation in HFMA at the national, regional and/or chapter levels provides members with numerous opportunities for professional development, information, networking, and advocacy.

The Founders Merit Award Series acknowledges the contributions made by HFMA members. The Metro NY Chapter would like to congratulate the following members who received these distinguished awards during the Annual Business Meeting. We would also like to thank you for the time and effort you put in to help make our chapter great. Your dedication means so much to us all.

The William G. Follmer Bronze Award:
Michael Breslin, CPA
Timothy Weld, CPA
James Linhart

The Robert H. Reeves Silver Award:
Christian Borchert
Shivam Sohan, FHFMA

The Frederick T. Muncie Gold Award:
Christina Milone, Esq

The Founders Medal of Honor:
Maryann Regan
Diane McCarthy, FHFMA, CPA
Laurie Radler, FHFMA

Congratulations – and "Bravo" to you all! #NYStrong

Diane McCarthy, FHFMA, CPA
Immediate Past President
Metro NY Chapter HFMA

Metro NY Does It Again!

2019/2020 Yerger and Awards of Excellence Winners

Yerger Awards:

- ★ 3 Chapter Yergers – for the Executive Summit, MS Climb to the Top, and Digital Disruption event
- ★ 3 Regional Awards – for the Fall Annual Institute, Certification Review Session at the Fall Institute, and Regional Webinars

Chapter Awards of Excellence:

- ★ Silver Award of Excellence for Educational Quality
- ★ Bronze Award of Excellence for Certification

"This is once again proof that our chapter is one of the best in the country – and while we always set the bar high we never seem to miss. It is a testament to the hard work and dedication of all of you and I thank you again for your hard work. Kudos to all of you and thank you for your support this year." –Diane McCarthy

COVID-19: The Mother of Invention

The business side of healthcare is often viewed as lagging behind other industries when it comes to innovation. Reimbursement models continue to evolve through a slow and tedious process, which over the years has come full circle for some models. Billing and prior authorization processes have become even more complex, despite the advancement and innovations in technology. In many ways, we are still doing some of the same things we were doing 20 years ago, only faster and with less paper, but with more rules and regulations. Nothing revolutionary in our business model has really taken hold. The same is true for our patient intake processes.

Enter COVID-19

The COVID-19 pandemic has prompted a lot of change in a very short time, probably more than anything else in the last 20 years. Innovations such as telemedicine are at the forefront of technologies that nearly all providers are rapidly deploying. Infection control has taken on a life of its own, both in and outside of a healthcare setting.

Gone are the days where patients arrive at a facility and proceed to the waiting room, signing-in on a pad of paper at the front window. No longer are registrars handing new patients a stack of paper forms to fill out, attached to a clipboard, and a pen to use -- the same pen and clipboard used by numerous patients before them. No longer are magazines shared among the patients in the waiting room.

Necessity: Virtual Intake Management

Necessity truly is the Mother of Invention and health systems around the country have all found unique and innovative ways to address the need for social distancing, use of face coverings, waiting room avoidance, and touchless registration. Tents have been set up in parking lots, patients have been asked to stay in their cars until it is time to be seen. Attendants are deployed to manage the intake process under those tents and in those parking lots, speaking with patients through open car windows, wearing clear plastic shields and masks, carrying mobile devices with the day's scheduled patients. Patients are being digitally screened for fever before being allowed into buildings.

Out of necessity, new tools and technologies are rapidly being developed and deployed to address this new normal in a more automated fashion. Virtual Intake Management solutions are part of that new class of technology starting to take shape.

Self-Registration

No longer should patients be asked to arrive early for their appointment so they can complete a stack of forms by hand, including medical history, demographics, insurance information, and consent forms upon arrival, only to be re-keyed into an EHR system by a staff member. Digital forms are available, and data captured from these forms should be automatically uploaded into the EHR and systematically reviewed and validated. Processes like insurance benefit verification (or eligibility), identity confirmation, address verification and other processes should run automatically, providing organizations with near instantaneous feedback on the data collected.

Appointment Reminders
Text messages, voice messages, and even human calls have been around for a long time, reminding patients of an upcoming appointment. These processes have been widely used to avoid patient no-shows, maximizing staff productivity and revenue. In our new virtual intake world, this messaging becomes even more important, providing patients with instructions on what to do when they arrive for their appointment. Links embedded in text messages can be used to signal their arrival for their appointment and initiate remote check-in processes from a mobile phone or tablet.

Digital Forms and Documents
In our new virtual intake world, forms are sent to the patient and signed electronically using a patient's mobile phone or tablet. Digital phone cameras are used to photograph insurance cards, driver's licenses, and other forms of ID. Verbal consent instead of signatures are used in some instances.

Patient Self Check-in on their Device
A patient has arrived in the parking lot of the facility where they have an appointment scheduled. They click on the link embedded in the text appointment reminder and a check-in form is presented. In some scenarios they might input their parking space number along with the make and model of their car. Additional information which may be needed for them to check-in is sent to them via the mobile-enabled check-in application. Tablets, kiosks, and clipboards are last-resort options.

Patient Payment Estimation & Collection
An estimate of the patient's out-of-pocket expenses is sent to the patient via the check-in application offering them options to pay today's payment due. Prior outstanding balances are included in the estimate and even financing alternatives are presented. Up-front collections increase because it is as convenient and as simple as paying for an online purchase. Patients receive a pleasant and safe experience and loyalty grows.

Virtual Waiting Room Dashboard
Staff members in the acute or ambulatory facility view a dashboard that updates every 10 seconds, displaying a list of the patients along with their arrival time, appointment time, and the provider they are here to see, or the purpose for their visit. Patient names are color-coded showing high, medium, or low priority. The location of each patient is displayed (parking lot, or lobby), along with any special requests such as a wheelchair.

Secure Patient Communications Throughout
The patient waiting in their car receives a text message indicating that it is time for them to come into the facility along with specific directions. Patients that have been waiting for longer than 15 minutes are sent a message apologizing for the wait-time and advising them of when they are expected to be seen. Family members that are accompanying the patients are also part of the communications loop. They go directly to the exam room or department avoiding unnecessary contact.

The New Normal
COVID-19 has forced many changes upon us, some that we knew needed to happen anyway. Oftentimes, however, we need a catalyst to force those changes. Sometimes the catalyst is a government

mandate (ICD-10, Transparency) with ample time to prepare, or through changes in market needs, or because of an unforeseen coronavirus that gives you no warning. As with most catastrophes, we get through them and find we are stronger and better prepared for the next one that comes along.

Author: Mike Bickers
Director
PELITAS – Best in KLAS 2019 & 2020
www.pelitas.com

Mike has more than 29 years of experience in healthcare revenue cycle technology and services. He is an expert in workflow process evaluation for hospitals and clinics in the areas of patient access management, denial management, and A/R recovery.

Mike has been a member of the Healthcare Financial Management Association (HFMA) since 2001. He has served in numerous committee and Board roles, including President of the Florida Chapter for 2017-18 and is a past Education Committee Volunteer for the Metro New York Chapter of HFMA.

PELITAS provides comprehensive patient access solutions to healthcare organizations nationwide including a suite of Virtual Intake Management solutions.

PELITAS
INCREASE CASH. CULTIVATE LOYALTY.

THE VALUE OF CERTIFICATION

Many healthcare organizations in today's challenging economy recognize their workforce as their most valuable asset. As such, these organizations tend to hold workforce development as a primary business strategy.

Investment in developing the talents, knowledge and skill sets of staff is critical to organization success. HFMA's Healthcare Financial Pulse research identified this dynamic and noted that successful organizations today commit to the "bread and butter" of financial management, i.e. technically strong and comprehensive financial management.

Likewise, many individual financial managers today recognize the importance of assuming personal responsibility for their career's success. More than ever before, individuals understand the importance of acquiring and maintaining comprehensive skill sets to ensure their ability to provide the financial management demanded today. These individuals frequently seek out relevant professional development opportunities.

The larger business environment resulting from these forces is a heightened interest in workforce development initiatives including certifications and credentialing. Credentialing programs have exploded across the past couple of decades and include:

- Professional associations offering certifications
- Community colleges offering curriculum-based certificates
- Corporate sponsored in-house credentials for employees
- Technology companies providing proprietary credentials to customers

HFMA certification provides a fundamental business service to our industry, namely HFMA certification offers:

- Assessment of job-related competency
- The opportunity for an individual to demonstrate skills and knowledge
- Independent verification of the skills and knowledge
- Confirmation that an individual is current in the practice field

The value of HFMA certification can be seen in several reported "value-adds":

- Increased departmental cooperation
- Heightened self-confidence among participants
- Increased performance against selected metrics
- Verification of staff knowledge and skills
- Assistance in structuring career paths

HFMA is committed to being the indispensable resource that defines, realizes and advances healthcare financial management practice. As such, HFMA provides professional certifications to achieve this purpose in today's business environment. This makes HFMA Certification a smart workforce investment strategy.

For more information on HFMA Certification, visit http://www.hfma.org/certification/

CONGRATULATIONS TO MEMBERS WHO EARNED CERTIFICATION IN 2019-2020

CHFP

Alyson Belz
Paola Benitez
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Darian Rodriguez
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For more information on HFMA Certification, visit http://www.hfma.org/certification/

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For over 40 years Betz Mitchell has solidified our position as a leading healthcare receivable adjudication firm. Our firm's history of excellence is demonstrated through the long-term relationships forged with multiple hospitals, skilled nursing facilities and network hospital systems throughout the New York Metropolitan area. The trust and respect that Betz Mitchell has gained from our clients is a direct result of productivity, industry expertise, and a proactive approach when developing and implementing unique and effective programs to maximize revenue.

From Betz Mitchell's inception in New York in 1977, we have operated and grown successfully as an organization working initially with traditional collections. Through the spirit of vision, innovation, and execution, we have maneuvered our company into an organization providing specialized lines of revenue cycle services. We now have over 3 decades of experience in providing exceptional services for the entire revenue cycle, spanning from patient access to bad debt collections. Our portfolio of services is in place in 30 acute care facilities and over 10 skilled nursing facilities:

- **Medicaid Eligibility/Patient Financial Advocacy**
- **Workers' Compensation and No-Fault Billing/Arbitration & Litigation**
- **Third Party Acceleration Billing & Follow Up**
- **Self-Pay Receivable Management & Bad Debt/Legal Collections**
- **Skilled Nursing/Long-Term Care Receivable Management**
- **Healthcare Consulting & Interim Staffing**

An integral part of our success is the diverse personnel on our team that work alongside our clients every day. We look forward to bringing our level of tenacity, and years of experience to your organization. We are confident that our innovative approach ensures we not only meet, but also exceed expectations. Please contact us to learn more about the solutions we provide.

POSITIVE CHANGE IN A CRISIS

How can leaders rapidly create the sustainable, wholesale change required to recover from the Covid-19 crisis and create a 'new normal' for their organization?

In addition to needing to combat the obvious economic pressure of a looming global recession, the current crisis has shown that organizations must also protect themselves against longer term uncertainty. As a result, there is an opportunity now to execute a systematic approach to accelerated change that, if done properly, can become the blueprint for a significantly leaner and more adaptive organization.

After the initial response to the Coronavirus crisis, characterized by swift expense reduction measures and government subsidies, CEOs are turning their attention to a more considered approach to longer term corporate sustainability. However, in the space of a few short weeks, the playing field has changed dramatically. Winners and losers are being defined by actions over a matter of weeks rather than months and years; regardless of size, geography, or industry, every organization now has to become more responsive. Yet despite the initial flurry of activity and decisions, clients are telling us that uncertainty is leading to paralysis. They know they need to figure out a new operating model – take out cost, identify new revenue streams, define new processes, restructure the balance sheet – and they need to do it quickly, but how and where?

For most organizations, innovation and change are infrequent events that carry a high degree of risk; there is no playbook for how to rapidly adjust to a changing market and operating environment. Now, enabling change is a strategic priority that cannot be seen as an exceptional occurrence; the ability to respond quickly, once the wheelhouse of the able start-up, must become the norm for every company and for most organizations it will depend on a fundamental shift in practices and in culture. In practical terms, achieving this will require a two-part approach. Part one is to quickly identify and approve the changes to the operating model required today and to create a roadmap for implementing those changes. Part two is to simultaneously build the capabilities and framework for ongoing accelerated change so that rapid, executable innovation becomes business as usual and the organization can withstand future shocks.

The question is, what is this approach that companies should be using now and in the future? It sounds obvious, but a successful change program needs the best initiatives, articulated in a granular unambiguous way that provides a clear route for implementation. The challenge is how to identify those initiatives and start implementing them quickly. The solution lies in engaging with your people. From experience, we see that successfully engaging employees is the single biggest success factor for a change program and that not engaging appropriately can undermine change efforts. There are many benefits from positively leveraging your workforce but three stand out when it comes to change:

Firstly, the collective internal insight of departmental or functional managers and their teams is a powerful, and usually untapped, source of the most relevant, highest impact opportunities for change. Lew Platt, former CEO of Hewlett Packard, once said "If

only HP knew what HP knows we would be three times more productive." Now, more than ever, harnessing that internal insight ensures that changes identified are feasible and pragmatic in the context of that particular organization.

Secondly, engagement builds accountability for, and ownership of, change. Ensuring successful implementation requires people to behave differently. These changes in behavior can be achieved most effectively and efficiently when those required to adjust are the ones driving it.

Thirdly,by decentralizing responsibility for innovative thinking and opportunity development an organization can achieve change at scale. In our experience, every single area of an organization, no matter how efficient, will have scope for improvement. We have found that a focused process for eliciting improvement opportunities will generate a portfolio of initiatives where, on average, 50% of the value will come from 10% of the ideas. In other words, half the value is derived from many small to medium ideas. Surfacing these ideas for each department across the entire organization is how you get wholesale change.

So, how do you go about creating an accelerated change framework that engages your workforce and leads to actionable, sustainable change? We have developed a model of the Six Disciplines of Accelerated Change which captures the essential features to incorporate into an effective rapid change program. Each element is important, and none can be left out; it is the precise execution and enforcement of all of these that guarantees success:

1. A sprint approach and mindset: Keep the cycle for identifying, evaluating, and approving changes short; the ability to adapt quickly and pivot in different directions is essential for reacting to uncertainty and requires agile decision making. The organization will be bursting with ideas and surfacing them is easy. The process tends to fall down, however, in a laborious set of activities and hurdles required to turn ideas into initiatives and get them approved. Procrastination, over study, and avoidance are eliminated in a process that establishes a clear goal with a short timetable and a 'test and discard' mindset. With a systematic, focused effort, this process can be streamlined into a matter of weeks by identifying what information is really required and limiting stakeholder involvement to those who really need to be, rather than want to be, involved.

A banking client once maintained that they were unable to reduce the number of deposit products they had because they did not have the resources required for the 6-month project to figure out which ones were really needed. Nor were they able to drive consensus among the scores of product managers, relationship managers, and executives who needed to have a voice. However, a focused 6-week effort involving just five key decision makers, supported by precise analytics, developed a plan to reduce the number of products from 440 to the 95 that accounted for 90% of deposit volume. Not only were the savings significant but, more importantly, a new protocol was established for addressing complex, cross siloed issues in an efficient and rigorous way using small, targeted multi-disciplinary taskforces. This type of approach to agile, collaborative problem solving creates faster resolution of big, complex issues resulting in more efficient change.

2. Architecture to promote participation and collaboration: The right infrastructure will support engagement and help to optimize the process. This can partly be achieved through ensuring technology solutions are in place to facilitate interactions, collaboration, and communication. This is

is clearly essential given the currently high levels of remote working, and therefore participation, that most organizations are experiencing. Idea management platforms can also help with organizing and developing initiatives in a consistent, accessible format; the more sophisticated of these can capture supporting financial and implementation data. Equally, if not more important than these practical tools, however, are 'rules of engagement' to govern behaviors and make participating in the effort free from negative consequence. Internal habits, politics, and biases conspire to prevent complex and transformational change programs from being successful. In the banking example above, a desire not to upset the status quo and an irrationally interpreted fear of impacting customers contributed to a complete lack of proactivity around managing product proliferation, even though it was widely understood as an issue within the bank. In a healthcare client, a lab technician had been trying to change protocols for 8 years with an idea that ultimately saved the company $1m, but her attempts were thwarted by a manager fearful of being asked "why haven't you already done this?" Mechanisms to protect individuals from recrimination for identifying issues and opportunities, to force collaboration particularly across silos, and to build cohesiveness are all required to create an open environment that fosters positive participation.

3. Visible and consistent leadership: The CEO and leadership team must demonstrate visible sponsorship. This does not require much of their time but requires clearly signaling the importance of the project and leadership's commitment to its success. Messaging is critical and should be supported by a comprehensive communication plan that continues throughout the process to inform, encourage, and validate internal and external audiences. The expectation should be set that the whole organization will be actively involved in ensuring success. The notion of transparency needs to be reinforced throughout the project as this makes it difficult for others to obstruct the process. Actions can also be effective. For example, people recognized as 'high-flyers' should be selected for the internal project team. Not only will the project outcomes be better for it, but the profile of the team will be the first impression the organization has of how seriously the leadership is taking the project and its priority on the leadership agenda.

4.Transparent and objective decision-making: The ability to make good decisions quickly and easily is central to any change program. We have found that in many organizations, there is a tendency to invite more input into assessing the viability and risk of an initiative than is necessary. This overly conservative approach often leads to good ideas being rejected early in the process. In fact, an analysis of thousands of improvement initiatives across multiple clients and sectors shows that functional or business heads had the delegated authority to approve around 80% of change initiatives. Limit approvals to the individual with direct P&L responsibility for that specific idea, their line managers up to the leadership team, and only include stakeholders who have direct P&L impact from the initiative or are required for legal/ regulatory reasons.

In addition, ensure decisions are being made based on facts not opinions, biases or conjecture. A business plan showing the full net financial impact and the risks of the initiative must be developed for every idea submitted for approval, however small, and include written explanations from any stakeholder who is against implementing an idea that has a positive ROI. Taking this approach will ensure any decisions are efficient and objective, creating a portfolio of initiatives that are fully articulated prior to implementation.

5. Relentless measurement and tracking: From the very start there mustbe a bias towards implementation. As ideas are developed into initiatives, they should be tested against the organization's ability to implement them as well as for their financial impact. Above all else, it is key that a single individual is accountable for, and committed to, implementing every initiative and achieving the target financial result. Typically, this would be the manager with the greatest P&L impact resulting from that initiative. Having named responsibility for an initiative improves the quality of that initiative, the robustness of the business case behind it, and the certainty of it being implemented. This accountability cannot be delegated or outsourced. Furthermore, tracking, measuring, and reporting are integral to implementation success. Ensure robust metrics and straightforward routines for continuous monitoring at the initiative level are in place and supported by mechanisms for intervening and escalating. This oversight is even more critical when many are working remotely, or new working practices mean that interactions are scarcer. Implementation oversight is relentless but essential, so put your best people on it, reporting directly and regularly to the leadership team.

THE SIX DISCIPLINES OF ACCELERATED CHANGE

6. Actively managing the emotional health of the organization: Making improvements necessitates change, and this causes anxiety at a personal and professional level. We typically see five phases to the 'emotional timeline' of a change program – Anticipation, Concern, Challenge, Engagement, and Validation. In an accelerated change program, responses are likely to be intensified and in times of crisis the whole organization can languish in the Concern phase in the absence of active intervention. Leaders who proactively take steps to manage the journey individuals are taking and find ways to support them through and shorten the Concern and Challenge phases are positioning a change program for greater success.

THE EMOTIONAL JOURNEY OF CHANGE

	TYPICAL FEELINGS	LEADERSHIP RESPONSE
ANTICIPATION	Nervous/skeptical but hopeful	Reassure and build confidence
CONCERN	Stressed and anxious about impact on me	Actively support and encourage
CHALLENGE	Defensive as controversies surface	Visibly lead, intervene and problem solve
ENGAGEMENT	Cooperating – willing or resigned – todrive good outcome	Constructively push and set expectations
VALIDATION	Relieved and empowered	Congratulate and reward

While every organization is different and faces its own unique challenges, applying a methodical, comprehensive approach to change that gives as much weight to people and behaviors as it does to tasks and deliverables, can quickly drive positive change. Designing an approach to change that systematically applies each of the six disciplines can form the basis of a framework that will foster resilience in an organization and provide a mechanism to respond to future shocks.

Melanie has 20 years of experience advising on strategic and operational change. She has worked with clients across a range of industries including healthcare, financial services, insurance, media, consumer goods, pharmaceuticals, and retail. Prior to joining Vici, Melanie was co-head of its earnings improvement subsidiary, Promontory Growth & Innovation. Earlier, she worked both as an independent consultant and for McKinsey & Company where she was part of the Financial Services and Growth practices. Previously she was a strategy director for Reuters Plc and began her career as an investment banker working first for Hambros and then Kidder, Peabody Inc. where she advised on M&A, fund-raising and corporate finance transactions across Europe and North America.

Melanie holds a law degree from the University of Bristol and an MBA from London Business School where she was awarded a Friends Scholarship.

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VICI

HFMA's Online Membership Directory

Have you visited HFMA's Online Membership Directory lately? Log in at www.hfma.org. When you select "Directory", not only can you search for members of your Chapter, you can also search for all your HFMA colleagues by name, company, and location – regardless of Chapter! Using an online directory instead of a printed directory ensures that you always have the most up-to-date contact information.

It's vital that HFMA has your correct information, so please take a moment to review your record now. By doing so, you'll ensure that HFMA continues to provide you with valuable information and insights that further your success.

hfma Your Challenge. *Our Mission.* 20-21

WE ARE PLEASED TO ANNOUNCE
THE WINNERS OF THE

MARVIN RUSHKOFF SCHOLARSHIP

SYLVANA BONACCI, DEVIN BATHEJA, ANDREW FARINA AND PAT KERN

EACH RECIPIENT WILL BE AWARDED $1,000 FOR ONE YEAR AT AN ACCREDITED COLLEGE OR UNIVERSITY.

Winners were selected based on the following criteria:

Essay	60%
Community/Professional Experience	25%
Field of Study	10%
GPA of most recent semester completed	5%

Eligibility Requirements:

Member in good standing with National HFMA and Metro NY Chapter.
Must be a member or spouse or dependent of a member.
Must be attending an accredited college or university.
Must provide proof of acceptance.
Must be a matriculated student.

**Members of the Executive Committee/their dependents and spouses are not eligible.
**Members of the Evaluating Committee/their dependents and spouses are not eligible.

hfma Your Challenge. Our Mission. 20-21

MARVIN RUSHKOFF SCHOLARSHIP

Sylvana Bonacci

My name is Sylvana Bonacci and I believe that I am an excellent candidate for the HFMA scholarship. Over the last seven years I have devoted my time and energy to caring for my family and raising my three young children. We are a family of five with one income and I made a choice to give my time to our children, to better their days and nights by being attentive and present. When I began going back to school two and a half years ago, I felt nervous. I doubted that I would be able to jump back in and do all of the work, I had all but assured myself that I wouldn't be able to pass my classes, so I began taking the classes I expected to be the most difficult, telling myself that if I failed, I obviously didn't have what it would take. I felt worried that the money we had budgeted and saved for me to afford school would be wasted. The first course I took was statistics, I received an A but I believe that my class grade was 103. I had pleasantly surprised myself and so I signed up for Anatomy and Physiology with the lab, thinking that the success in stats had been a fluke. Again, I received an A. With each successive semester I not only succeeded, but excelled, earning all A's. I began to feel confident, a sense of belonging, and that I am enough. I now know that as long as I work hard, remain focused diligent, and determined I will find success in all that I do.

I was recently accepted into the Nassau Community College multi-award Nursing program and will begin this fall. I am proud and excited to finally be working towards what I have wanted for so long. My long term goal is to continue on eventually earning my Masters of Science in Nursing and complete a program to become a Certified Nurse Midwife. This scholarship would help to lessen the financial impact that my schooling has placed on our family.

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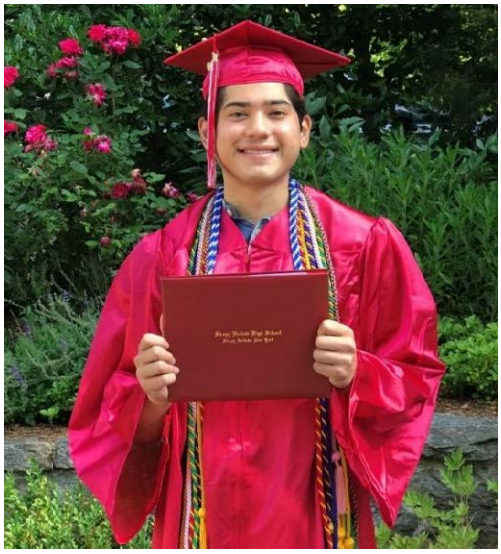
MARVIN RUSHKOFF SCHOLARSHIP

Devin Batheja



With all the uncertainty everyone is facing right now due to COVID-19, I believe that it is important to keep my goals in sight and stay positive. I will be attending Union College in the fall, but it is uncertain whether it will be online or in person. I had planned on having a wonderful senior year, with an amazing prom and a senior baseball season, all culminating in the graduation I had been working towards for years. These were some of the things I took for granted, and now they're gone. I realize that instead of dwelling on what can no longer happen, I have to stay focused on my goals and work even harder to ensure that I accomplish then.

I shadowed in an ICU during my sophomore year, where I met a woman who only spoke an Asian language and couldn't communicate with the doctors or nurses. She was alone and scared, and needed someone to comfort her. I was able to calm her down and be there for her when she needed help the most, and making a difference in her life inspired me to pursue the path of medicine. While on opposite sides of the industry, both my parents work in the healthcare field. My dad works in healthcare finance and my mom is a primary care physician. My goal is to become a doctor like my mom and grandfather. Similar to my dad, I also want to better understand the economics of healthcare in order to effectively meet the needs of patients.

In order to build on my strong science background, I will major in chemistry in college with a science research initiative. I will also broaden my horizons and learn about new subjects such as computer science and business. If I am fortunate enough to be awarded this scholarship, I intend to use it to help start or join an independent research project. Be assured that I will make the most of this generous award, just as I plan to make the most of my current situation and my future.

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MARVIN RUSHKOFF SCHOLARSHIP

Andrew Farina

Reflecting upon all that I have learned through my different experiences in college, the role of a Physician Assistant has illuminated itself to me as the career path that I desire most, and the duty that I want to fulfill. My experience working with near strangers in critical situations as an EMT greatly strengthened my teamwork skills. The rigorous course load that I completed during my undergraduate degree further developed my problem-solving abilities. My time abroad allowed me to interact with numerous cultures, giving me more perspective.

Curing the patient is always the goal but *caring* for them is what I believe to be meaningful. Talking to a patient after performing CPR on them is one the most marvelous and unbelievable things I have done. However, I have also come to value the time spent on a transport ambulance with a patient whose diseases I can hardly help. Having the time to learn about their life, making them laugh, and learning about them as a person and not just a patient is something I want to continue to do as a PA. While I love science and know that the work of researchers is invaluable, I belong in the room with a patient, not in a lab with a microscope. Nothing can imitate the feeling I get when I breathe life into somebody with a BVM. Simply holding someone's hand, telling them that help has arrived is a beautiful moment. I would not say the feeling I get is a euphoric adrenaline rush, like something you get from skydiving. Rather, it is a perfect feeling of belongingness, that I am acting out my purpose and doing an objective good.

My family was gracious enough to finance most of my undergraduate education, yet the financial burden of doing so mandates that I personally pay for PA school. The Marvin-Rushkoff scholarship will help pay for tuition and allow me to study more to become the best PA I can be, instead of having to sacrifice valuable study time and work while pursing my graduate degree.

hfma Your Challenge. Our Mission. 20-21

MARVIN RUSHKOFF SCHOLARSHIP

Pat Kern

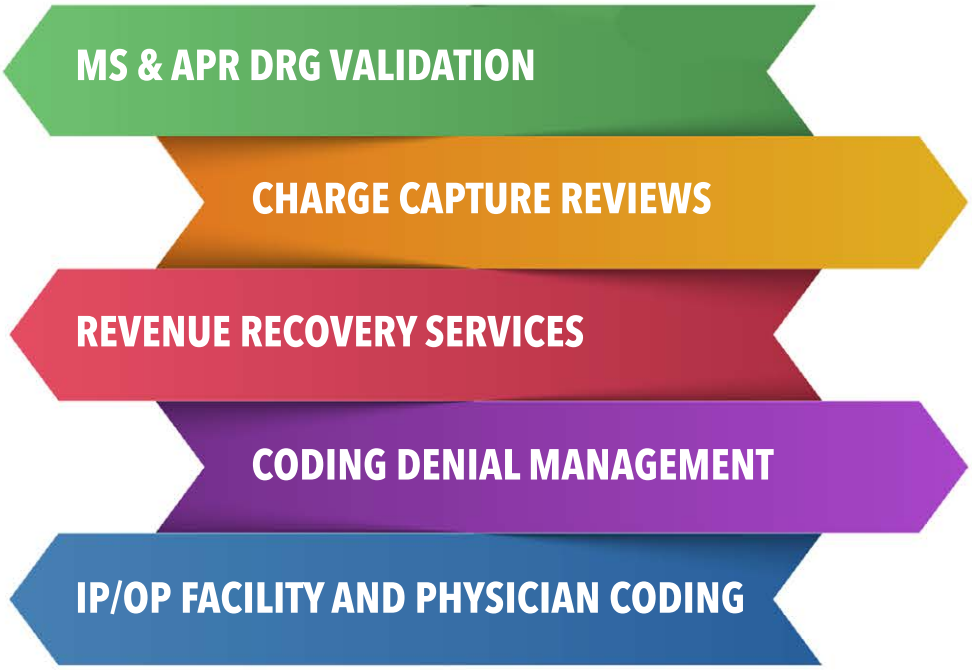
I didn't care for education in High School. I told myself I'd always "figure it out", later on in life. I focused on sports and fortunately, I was good enough to leverage my athleticism to receive a lacrosse scholarship to Molloy College. This was basically my only option as my GPA was atrocious, so I took it. I declared as a History major because I wanted to be a teacher so I could coach lacrosse. My life was sports.

Before arriving on campus, I started asking my mother questions about the economy, how businesses operated in the world, and her knowledge was insightful. It wasn't even freshman year yet and I was changing my major into business. But something still didn't feel right. I went through two years of school at Molloy College and played on the lacrosse team. It was the first time I was fascinated by a subject and it led me to having a GPA of 3.7 over the span of two years. I balanced lacrosse, working several jobs, and school. But something still wasn't right.

In the middle of sophomore year I determined that the Molloy College Business program was not providing me with the best of resources. I also determined that I wanted to major in something more specific. I explored my options and recognized the shift in Finance from traditional investing to investing via technology and that was something I wanted to be a part of. I looked up schools that offered such a program and Baruch College stood out to me. I transferred and become a Statistics and Quantitative Modeling major. I gave up on my old high school dreams, to pursue new ones.

My goal is to work for a quantitative fund or in data analytics after I graduate. If I were to win this scholarship, I would use the money to take a summer course at Baruch College to further my education in computer programming. Thank you for taking the time to read my story.

JZANUS CONSULTING PROVIDES FINANCIAL EXPERTISE TO HELP CLIENTS DRIVE REVENUE CYCLE PERFORMANCE



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NEW PRICE TRANSPARENCY RULES: 5 STEPS HOSPITALS SHOULD TAKE TODAY

Since the passage of the Affordable Care Act, price transparency has continued to develop momentum by our elected leaders as part of a larger solution set in reducing healthcare costs – especially as consumers are burdened with carrying a greater percentage of those costs now and likely into the foreseeable future.

Initially, the Affordable Care Act required hospitals to provide their posted charges online effective October 1, 2014. However, given the wide range of negotiated rates from non-governmental payers, it was rapidly determined that a hospital's posted charges were not going to provide the intended outcome since it did not reflect accurately on the portion of the charges that would ultimately be the responsibility of the patient and/or guarantor.

And as such, on November 15, 2019, the Centers for Medicare and Medicaid Services (CMS) finalized policies that expand upon previous pricing transparency guidance from CMS and the directive under President Trump's Executive Order "Improving Price and Quality Transparency in American Healthcare to Put Patients First." These policies provide more specificity on what information hospitals need to make public. These include requiring hospitals to:

1. Publish a list of standard charges (including gross charges, discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated reimbursement) for all items and services[1]; and,
2. Publish the discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated reimbursement for at least 300 "shoppable" services - 70 CMS-specified, 230 hospital -selected[2] (CMS-1717-F2, November 15, 2019).

Under this rule, CMS has authority to monitor and enforce hospital compliance and to assess civil monetary penalties (not in excess of $300 per day) for non-compliance. The effective date is January 1, 2021.

WHAT SHOULD HOSPITALS DO NOW TO BE READY FOR IMPLEMENTATION OF THIS REGULATION?

1. Assess Chargemaster:

Now would be the ideal time to evaluate your current chargemaster. Hospitals will want to review for obsolete codes, for items that have just been inflated over the years without a strategic pricing rationale and to identify any unexplained pricing variations. For example, are comparable items priced similarly?

1 This information must be posted on the internet, in a consumer friendly, machine-readable, searchable format, with enough billing code details to allow for comparisons between hospitals

2 See footnote 1

Pay close attention to the pricing for "shoppable" services to determine if your hospital will be at a disadvantage amongst neighboring hospitals when this information is published. Identify any unusually high price items that would not reflect properly against the hospital's actual costs. More specifically, evaluate the price for items patients can easily compare, like over the counter medications and supplies. What is the markup percentage? Is it reasonable compared to neighboring hospitals, your costs and what you receive in reimbursement from non-governmental payers along with the patients and/or guarantors? Best practices consist of evaluating your chargemaster annually to ensure it's accurate, that all of the items departments need to charge are included and that obsolete charge codes are deactivated.

This is a great time to define the overall pricing and communication strategy that will provide talking points to the organization's pricing philosophy. For example, is it based on cost or is it strategically priced to offset losses in mission-critical community services?

2. Assess Quality Scores:

President Trump's Executive Order challenges the various governmental agencies responsible for healthcare to standardize quality reporting. This is a perfect time to focus your clinical documentation improvement (CDI) program onto key quality indicators. You will want to coordinate the efforts across coding, quality, and CDI.

A focused effort on raising quality scores or increasing acuity levels will also help connect price with quality. It's an opportunity to highlight the high quality of services provided.

In addition, as more governmental and non-governmental payers find ways to reduce costs, quality metrics will likely be the next significant wave that impacts a hospital's ability to maintain proper margins.

3. Review All Revenue Cycle Vendor Contracts:

Hospitals should assess whether they can comply with the new regulations with existing systems and services. Are your vendors contractually obligated to help you become compliant? If so, is there a plan?

If they are not contractually obligated, how will your hospital vendors assist you to become compliant? Hospitals should determine the responsibilities of each internal team and outside vendor(s) to ensure a proper accountability structure is in place.

4. Review All Payer Contracts:

Prior to the next negotiating cycle, review the payer contracts for any anomalies in core pricing philosophy. Is there pricing in your hospital's chargemaster related to a few payer specific pricing? Do you have services priced 20% - 50% higher than what the non- governmental payers made in reimbursement? As your hospital approaches negotiations with each non-governmental payer, it is in both the hospital and the payer's best interest not to have any large variation in reimbursement for services and items.

Hospitals will need to evaluate the contract modeling capabilities to model payment for services and items based on the complexity levels of various plans. For example, does your hospital have one payer that pays 20% more than any other for a particular service? Will this be considered a shoppable service?

5. Provide Education, Training and Appropriate Tools to Your Patient Facing Staff Including Patient Access, Customer Service, And Scheduling:

Hospitals should evaluate their pricing or estimator tool. Does it return accurate information at the time of service? Is this tool being utilized at all access points?

Now is the time to start inservicing your customer service teams on the proper response to patient inquiries. They will receive questions from patients on pricing variations and they need to be prepared to answer them. They will also need to be able to explain that the reimbursement information provided does not take into consideration the patient's responsibility due to the amount of their deductible that may have been partially/fully satisfied prior to a pending or recent visit at your hospital. Consider posting links from the hospital website to the payer's websites so patients can easily navigate to their own plan to see what information the payers have available, especially with respect to the patient out of pocket costs.

Hospitals should add disclaimers that any information provided is an estimate and the patient's actual invoices will be based on individual plan benefit information.

CONCLUSION

It is worth noting that CMS may not have the legal power to require hospitals to reveal prices they negotiate with insurers as recently reported in *Modern Healthcare*. Regardless of the legal challenges ahead, it is safe to state that price transparency will continue to make headlines and therefore many of the suggested steps in this article will likely help hospitals in dealing with this issue and improving financial/operational metrics overall.

REFERENCES

CY 2020 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Rule (CMS-1717- F2); https://www.cms.gov/newsroom/fact-sheets/cy-2020-hospital- outpatient-prospective-payment-system-opps-policy-changes-hospital-price; November 15, 2019

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Peter's industry-specific expertise has allowed him the ability to provide transformational leadership to hospitals, healthcare practices, and nursing homes by paving the way for sustainable changes impacting operations, profitability and revenue retention. In addition, Peter's level of guidance and insight has made significant differences for healthcare organizations dealing with skyrocketing healthcare costs.

Peter is also responsible for assisting his clients with Revenue Cycle transformation, coding and documentation assessments, ICD-10 assessment and implementation, clinical education strategy and improvement planning development, charge capture with Charge Description Master Support, and regulatory compliance matters. His industry experience covers Inpatient Acute, Post-Acute (SNF, LTACH), Outpatient Hospital and Free-Standing Diagnostic Centers, and Physician Practice in all settings.

He has deep experience around workflow process redesign, dashboards and policy and procedural development in conformance with all federal and state regulatory statues. In addition, Peter has developed and implemented process mapping and policies and procedures to provide guidance in the areas surrounding internal and external industry practices, terms and definitions, directives, deference programs, technology strategy and vision, training resources and performance measurements.

Peter also has performed significant work around the improvement of patient satisfaction scores and wait times through a programmatic approach which allows for application of process to ensure better and consistent through-put.

Peter has deep knowledge around DRG, APR-DRG, APC and APG payment systems, RAC, CDI, ICD-10 and CDM to assist in the performance of revenue cycle and charge capture initiatives.
He has conducted numerous denial reviews throughout the revenue cycle process to identify root causes necessary to develop intensified protocols to prevent reoccurrence.

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Cheyenne has over 25 years of healthcare experience where she has demonstrated extensive Healthcare Financial Leadership skills including Revenue Cycle, Reimbursement and Regulatory Compliance, Mergers and Acquisitions, leading large-scale margin improvement initiatives, Vendor Management, contracting (payer and vendor), and Strategic Planning including new service development and market share strategies.

She has experience across the healthcare continuum including rural sole community hospital, multi-specialty physician group, skilled nursing, accountable care organizations and physician-hospital organizations. She has also led quality teams, with Finance and Quality being linked in value-based reimbursement. Cheyenne's industry-specific expertise has allowed her the ability to provide strategic guidance to healthcare leadership by paving the way to profitability and revenue retention.

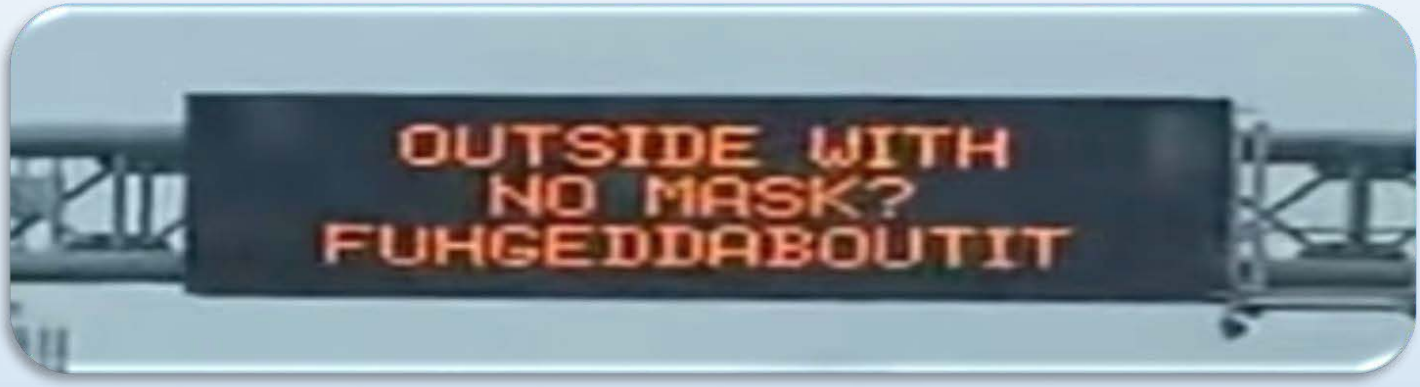
Prior to MazarsUSA, she was the Chief Financial Officer of a member hospital of the University of Vermont Health Network.

Cheyenne has a Master of Science in Management-Healthcare Administration from Southern New Hampshire University and a Bachelor of Science from the University of Vermont. She is a licensed Certified Public Accountant (NC) and is professionally affiliated with Healthcare Financial Management Association and American College of Healthcare Executives.

MAZARS

Scenes across MetroNY

The COVID-19 Pandemic unleashed changes that seemed unthinkable a few months ago.



Quarantine birthday celebrations

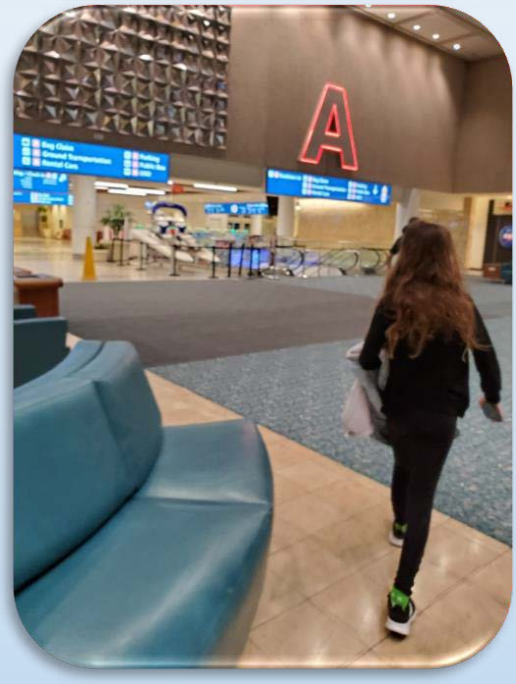
Drive-thru graduation

"Human beings can get used to virtually anything, given plenty of time and no choice in the matter whatsoever."
— Tom Holt,
Open Sesame

Yard and street sign recognition for graduates and virtual last day of school

Drive-by Wedding Receptions

Redesigned air travel and empty airports



A move from the large celebration to a more family-centric celebration

EVERY SUCCESS STORY IS A TALE OF CONSTANT ADAPTION, REVISION AND CHANGE."
– RICHARD BRANSON

You can conduct business by ZOOM!

Pupachinos are a real thing at Starbucks!

NEVER STOP LEARNING BECAUSE LIFE NEVER STOPS TEACHING.

Toilet paper is back on supermarket shelves

.....And most importantly, the hope it will be safe to resume new normal operations!

Celebrating the lives of:

Thomas Galvin

Father of Linda Brescia

October 29, 1937 – March 31, 2020

Norman Robinson

Father of Laurie Robinson Radler

May 8, 1930 – April 1, 2020

Arthur J. Cusack

Valued HFMA Member

November 6, 1962 – May 21, 2020

The MetroNY HFMA Chapter expresses our deepest sympathy.
May loving memories bring happy thoughts, smiles and comfort.

Fiscal Year 2021 Proposed Medicare DSH and Uncompensated Care Provisions

On May 29, 2020, the Centers for Medicare and Medicaid Services (CMS) published the proposed rule for fiscal year (FY) 2021 Hospital Inpatient Prospective Payment System (IPPS). The provisions of the rule, unless otherwise noted, affect discharge dates on or after October 1, 2020.

Each year, CMS publishes updates to the regulations for inflation factors, wage index adjustments, and other patient-care related payment adjustments. Below is an overview of the FY 2021 IPPS proposed Medicare Disproportionate Share Hospital (DSH) and uncompensated care (UC) provisions.

Background

Section 1886(r) of the Social Security Act requires that subsection (d) hospitals that would otherwise receive Disproportionate Share Hospital (DSH) payments receive two separate payments after 2014. The payments include:

- 25% of the pre-Affordable Care Act (ACA) amount.
- An additional amount based on three factors estimated by The Centers for Medicare and Medicaid Services (CMS). These factors and estimates are reported each year in the IPPS payment rulemaking issuance.

Eligibility

Eligible program participants include:

- General short-term acute care subsection (d) hospitals
- Subsection (d) Puerto Rico hospitals eligible for DSH
- Medicare dependent, small rural hospitals eligible for DSH—because they're paid the IPPS federal rate
- IPPS hospitals participating in the Bundled Payments for Care Improvement Advanced Initiative
- IPPS hospitals participating in the Comprehensive Care for Joint Replacement Model eligible

Organizations that aren't eligible include:

- Maryland hospitals
- Sole community hospitals paid the hospital-specific rate
- Hospitals participating in the Rural Community Hospital Demonstration Program

Proposed Changes

CMS is proposing updates to the Medicare DSH estimate as well as the three factors used to compute uncompensated care payments.

Medicare DSH

CMS used the most recently available projections of Medicare DSH as calculated by the CMS Office of the Actuary from cost reports to estimate what DSH would have been absent the ACA.

Calculation

The DSH estimate begins with a baseline year and then trends forward by a number of factors—IPPS updates, discharge adjustments, case-mix adjustments, and other adjustments—applied to the 2018 through 2021 periods. The baseline starting point for 2021 is from 2017 and is $14.004 billion.

From the chart on the right, the FY 2021 estimate of what DSH would have been absent the ACA is $15.359 billion. It's important to note that 2021 estimated DSH is $1.224 billion less than 2020 estimated DSH.

2017 Baseline		$ 14.004 B
2018 Update Factor	x	1.0508
		$ 14.716 B
2019 Update Factor	x	1.0022
		$ 14.748 B
2020 Update Factor	x	1.0069
		$ 14.850 B
2021 Update Factor	x	1.0342
2021 Estimated DSH		**$ 15.359 B**

Empirically Justified Medicare DSH

The resulting empirically justified Medicare DSH amount is $3.840 billion, which is 25% of $15.359 billion.

Update Factors Comparison

While the baseline DSH amount in the current and prior year is roughly the same, the projected update factors are significantly different.

YEAR UPDATE FACTOR	2020 CALCULATION	2021 CALCULATION
2017	1.0796	N/A
2018	1.0528	1.0508
2019	1.0121	1.0022
2020	1.0311	1.0069
2021	N/A	1.0342

Considerations

One of the most notable changes year-over-year appears to relate to the Medicare fee-for-service discharge assumption. It's worth noting that this is one of the items that comprise the factors above, which are detailed in the proposed rule. The amounts assumed for 2019 and 2020 are significantly less than what was assumed for 2019 and 2020 in the FY 2020 IPPS final rulemaking.

It's important to note that the discharge factor assumption attempts to factor in how many beneficiaries will be enrolled in Medicare Advantage plans.

Uncompensated Care Factor 1

Factor 1 is the difference between the CMS estimate of what DSH payments would've been under the pre-ACA formula and the 25% empirically justified amount.

Therefore, Factor 1 is projected to be $11.519 billion, which is $919 million less than the 2020 Factor 1.

Uncompensated Care Factor 2

Factor 2 is 1 minus the percent change in the percentage of individuals who are uninsured by comparing uninsured individuals based on the most recent period where data is available to the percent of uninsured individuals in 2013.

Data Source

The source of the most recent period data are estimates produced by the CMS Office of the Actuary (OACT) as part of the development of the National Health Expenditure Accounts (NHEA).

OACT estimates the uninsured rate in 2013 was 14%. For calendar years (CY) 2020 and 2021, OACT estimates the uninsured rates are 9.5% and 9.5%, respectively.

The CY values are then converted to the payment year using a weighted average approach. The weighted average is 9.5% because the estimated uninsured rate for CY 2020 and CY 2021 are the same.

Calculation

Factor 2 is then computed using the following formula:

$$1 - \left(\frac{9.5\% - 14\%}{14\%} \right) = 67.86\%$$

Percent change in uninsured rate — *Factor 2*

Therefore, Factor 2 for FY 2021 is 67.86%—a slight increase from 67.14%, the computed estimate of the uninsured rate for 2020 Factor 2**.**

Considerations

It's worth noting that this proposed rule was submitted to The Office of Management and Budget (OMB) in January 2020 for review and clearance. It's difficult to ascertain to what extent the projected uninsured rate was adjusted as a result of the economic reality of the COVID-19 pandemic.

This is certainly an item that should be probed with CMS through the comment process as one would expect that the uninsured rate in FY 2021 will increase from most recent years based on current economic circumstances, especially the level of unemployment, and that should be reflected in this estimate.

Uncompensated Care Pool

When Factor 2 is applied to Factor 1 ($11.519 x .6786), the result is an uncompensated care pool amount of approximately $7.817 billion to be shared by 2,401 qualifying hospitals based on their Factor 3 calculation.

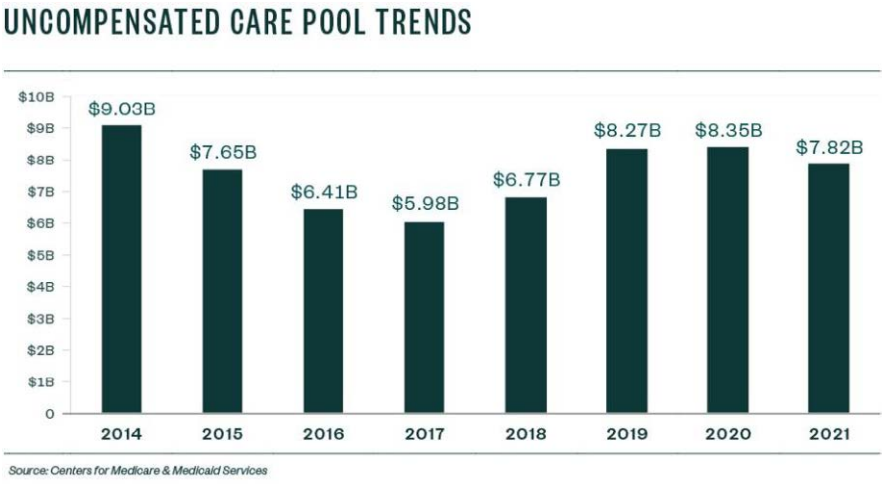
Trends

From a trend perspective, the UC pool in 2014 was $9.033 billion and then steadily declined as the rate of the uninsured declined in the US, or at least was estimated to decline using CBO data.

Since the switch from CBO data to NHEA data metric in 2018, and as a result of changes to

various factors that impact coverage decisions under the ACA, the rate of uninsured ticked up in 2018 and 2019 and nearly flattened in 2020 and 2021.

The size of the pool increased as pre-ACA DSH estimates have increased when more current fiscal years are used as the basis for computing the estimates of Factor 1, but for 2021, the pre-ACA DSH estimate decreased for the first time since the establishing of the UC pool.



Economic Impact

Based on CMS analysis, it's projected that FY 2021 payments under this methodology will be $534 million less than FY 2020 and continue to have a redistributive effect based on each qualifying hospital's uncompensated care costs relative to the total uncompensated care costs for all qualified hospitals.

Uncompensated Care Factor 3

Factor 3 is the percentage of each subsection (d) hospital's amount of uncompensated care as a percent of the uncompensated care of all hospitals qualified for payment from the uncompensated care pool.

Factor 3 is applied to the product of Factor 1 and Factor 2 to determine the amount of uncompensated care payment each eligible hospital will receive.

As in FY 2020, CMS is proposing to use one year of Medicare cost report Worksheet S-10 data to derive Factor 3 for FY 2021. CMS is proposing to use FY 2017 data for FY 2021 for all hospitals except Indian Health Service hospitals and Puerto Rico hospitals.

Indian Health Service and Puerto Rico Hospitals

CMS is proposing to use a low-income insured days proxy utilizing 2013 Medicaid days and the most recent SSI days to calculate Factor 3 for Indian Health Service hospitals and Puerto Rico hospitals for one more year.

Additionally, CMS plans to review a restructuring of Medicare DSH and uncompensated care payments beginning in FY 2022 for Indian Health Service hospitals and tribal hospitals. CMS is contemplating a Medicare DSH payment that's 100% of the calculated amount rather than 25% of the calculated amount.

Future S-10 Use

CMS also is proposing to use the most recent available single year audited S-10 data for Factor 3 in all subsequent years.

CMS expects the number of audits to increase in future cost reporting years, and as a result, believes that the best available data will be from S-10 data for cost reporting years for which audits have been conducted.

Considerations

Medicare Administrative Contractors (MACs) are currently performing Worksheet S-10 audits on all federal 2018 fiscal years. Given CMS Factor 3 proposals, it's likely that CMS rolls forward their methodology by one year using the federal 2018 S-10 data during the 2022 rulemaking cycle.

Additional Uncompensated Care Proposals

Proposed Definition of Uncompensated Care

CMS is proposing to use the definition of uncompensated care as reported on S-10 Line 30 for FY 2021 and subsequent years. Line 30 includes both charity and bad debt, but doesn't include Medicaid or other indigent program shortfalls.

Hospital Mergers

In cases where a merger takes place during a surviving hospital's cost reporting period, annualizing the uncompensated care data of the acquired hospital could double count the data for the portion of the year that overlaps with the remainder of the surviving hospital's cost reporting period.

To mitigate this double counting, CMS is proposing not to annualize the acquired hospital's data.

Instead, CMS will use a multiplier that represents the portion of the uncompensated care data from the acquired hospital that should be incorporated with the surviving hospital's data for the purpose of determining Factor 3 for the surviving hospital.

Newly-merged hospitals are hospitals that merge after the development of the final rule and will be treated as new hospitals. The newly-merged hospital's final uncompensated care payment would be determined at cost report settlement where the numerator of Factor 3 will be from the surviving hospital only for the current fiscal year.

If less than 12-months, the data will be annualized.

Long Cost Reports

CMS is proposing a modification to the annualization of long cost reports, in which a hospital's cost reporting period starts in one fiscal period and spans the entirety of the following fiscal year.

In this case, CMS would use the cost report that spans both fiscal years for purposes of calculating Factor 3.

All-Inclusive Rate Providers (AIRP)

In terms of cost-to-charge ratio trims, CMS is proposing that if the AIRP's total uncompensated care costs are greater than 50% of its total operating costs on its 2017 cost report, uncompensated care costs would be recalculated using a cost-to-charge ratio of the hospital's most recent prior year report that wouldn't result in uncompensated care costs greater than 50% of operating expenses.

Cost-to-Charge Ratio Trim

CMS will use a similar process to the one used in FY 2018, 2019, and 2020.

CMS will establish a cost-to-charge ratio ceiling that's three standard deviations above the national geometric mean cost-to-charge ratio of the applicable fiscal years used.

Uncompensated Care Data Trim Methodology

CMS will use the same methodology used in FYs 2019 and 2020. If a hospital's uncompensated care costs for 2017 are greater than 50% of its total operating costs, CMS is proposing to use the data from the hospital's 2018 cost report to trim the 2017 uncompensated care costs.

However, CMS won't apply the trim methodology to hospitals that were subject to an S-10 audit because CMS believes there's increased confidence that if high uncompensated care costs are reported by these audited hospitals, the information is accurate.

Interim Uncompensated Care Payments

CMS will continue to use the average of the three most recent years discharges for setting interim uncompensated care payments.

However, for FY 2021, CMS is proposing a voluntary process through which hospitals may submit a request for a lower per discharge interim payment amount if the hospital thinks it could be overpaid due to a spike in FY 2021 discharges.

This voluntary method should be considered if a significant recoupment, 10% of total uncompensated care payment or at least $100,000, would take place at cost report settlement if the per discharge amount wasn't lowered.

Accounting Standards Update (ASU) Topic 606

Another item from the rule that impacts S-10 reporting is where there has been some clarification on the topic of implicit price concessions as it relates to the Accounting Standards Update (ASU) Topic 606.

Based on the Financial Accounting Standards Board (FASB) update under Topic 606, an amount representing a bad debt would no longer be reported separately as an operating expense.

Instead, it would be treated as an implicit price concession and is a reduction in patient revenue.

There was a question with the implementation of this new standard and how it could impact Worksheet S-10 non-Medicare and Medicare bad debt. However, CMS addressed this issue as they're proposing to recognize the Topic 606 terminology and these implicit price concessions will be recognized as a bad debt on Medicare cost reports.

Next Steps

Final Rule Forthcoming

Hospitals should have reviewed data associated with this rule, including any tables, supplemental data files, and merger updates, as well as reported any issues or data discrepancies to CMS by the July 10, 2020 deadline.

CMS will review the comment submissions in preparation for publishing the final rule expected in August.

Providers will have another opportunity to notify CMS of any issues or data discrepancies, however, due to COVID-19, CMS is waiving the 60-day delay of the final rule effective date.

Instead, there will be a 30-day delay of the final rule effective date. Historically, there's a 60-day delay from the final rule publication date and effective date, so hospitals will need to be mindful of the shortened timeframe when reviewing their final rule data.

S-10 Audits

One major point that CMS addresses in this rule is the proposal to use the most recent available single year audited S-10 data for Factor 3 in all subsequent years.

This signals that the S-10 audits that occurred the last few years are here to stay, and that CMS expects there to be recent audits on these S-10s to pull for future Factor 3's.

CMS also states that they expect the number of audits to increase in future cost reporting years, and as a result, believes the best available data will be from S-10 cost reporting years that have been audited.

Hospital systems need to designate an individual or a team of individuals to prepare the S-10 for filing and support it during the audit process. These S-10 reports take a considerable amount of time and resources to prepare.

For the 2015 and 2017 reviews, the MACs budgeted anywhere from 80-120 hours for each review; even more time could be needed to prepare an accurate S-10. To accurately report charity and bad debt and to maximize the uncompensated care reported on S-10, there needs to be coordination between the designated S-10 preparer and reimbursement staff, revenue cycle, accounting, and potentially policy, compliance, or legal if revisions are necessary to any policy.

The designated S-10 preparer will also need to stay abreast of any regulatory changes regarding the reporting of S-10 along with updates on audit findings to better prepare their hospital for future S-10 reviews.

2019 Focus

Providers should take another look at their federal 2019 cost reports to make sure they've accurately captured all uncompensated care on those cost reports and decide if they need to amend before these are most likely subject to an audit early next year.

CMS now requires hospitals submit the patient detail that ties to the charity amounts claimed on S-10, as well as the Medicare DSH totals at the time of the cost report filing. The cost report will be rejected if not included.

This requirement begins for cost reports starting on and after October 1, 2018. CMS hasn't published an exact template for S-10, but hospitals will need to provide, at a minimum, the charity detail that ties to the cost report and include fields such as patient name, social security number, and write-off amount.

Michael Newell is a partner at Moss Adams and has worked in health care financial management since 1982. He's worked with hundreds of hospitals for thousands of fiscal years to prepare and review Medicare DSH and Worksheet S-10 for cost report filings. Michael can be reached at (469) 587-2120 or michael.newell@mossadams.com.

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Committee Chairs, or anyone else in need of volunteers, should send details to jdaly@millermilone.com.

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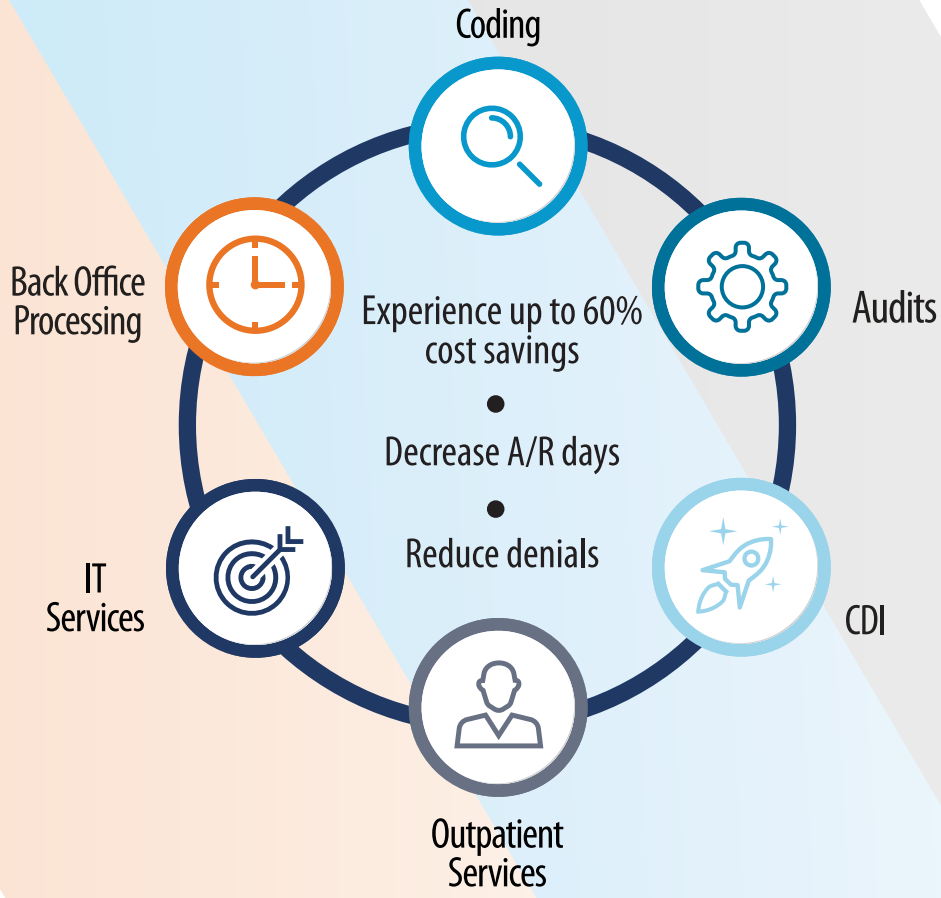

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