hfma

NEWSCAST

METROPOLITAN NEW YORK CHAPTER

SUMMER / FALL 2023

hfma IT'S TIME 2023-2024

PRESIDENT'S MESSAGE

As we enter the holiday season, it's hard to believe that my year as President of the Metro NY Chapter is already halfway over. The Chapter has had a very active summer and fall, including the annual Golf Classic, a Knowledge is Power event focused on women's health, a NY Mets game, the first finance conference of the year, the Making Strides breast cancer walk, and the Fall Institute, featuring a NY Islanders game.

We are already planning the Annual Institute in March, which is always the highlight of the year. I hope to see you all there, as well as at the Chapter's holiday party in December, the winter golf event in January, and all the other upcoming events for the 2023-2024 year. Make sure you are on our email list to receive up-to-date information about all the great events we have planned.

Dennis Dahlen, HFMA National Chair, has chosen "It's Time" as the theme for the 2023-2024 year. I would encourage all of us to embrace this theme and take action - get started, get involved, contribute. Let's all work together to make this a year of collaboration and accomplishment.

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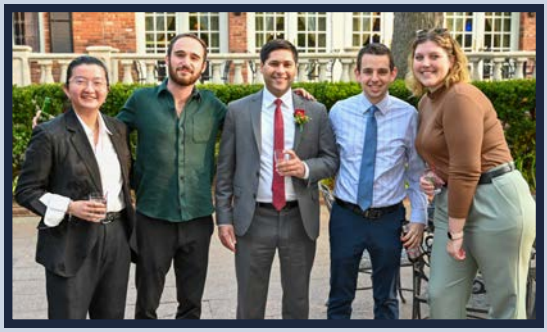
ANNUAL BUSINESS MEETING

May 10, 2023

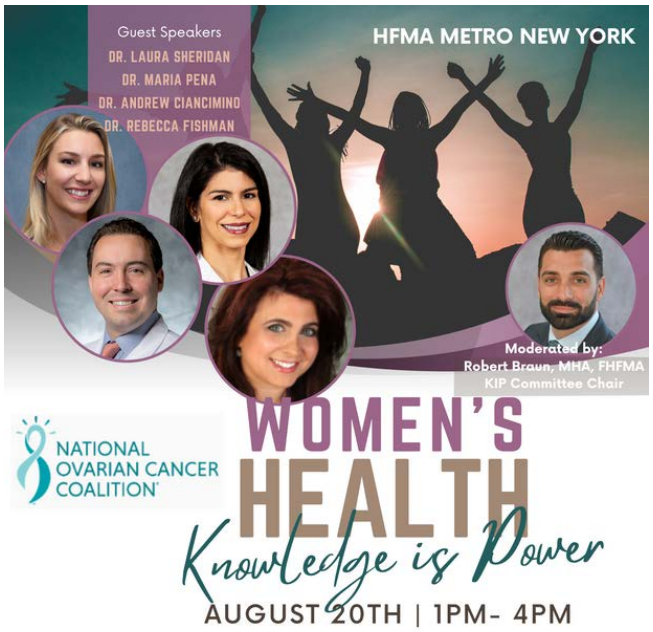


KNOWLEDGE IS POWER: WOMEN'S HEALTH

August 20, 2023

The Metro NY Chapter held a Knowledge is Power event focusing on Women's Health at Bella Notte in Bellmore. The event featured a diverse panel of physicians from the Catholic Health system: Laura Sheridan, Obstetrics and Gynecology; Maria Pena, Endocrinology; Andrew Ciancimino, Internal Medicine; and Rebecca Fishman, Physical Medicine and Rehabilitation. Their broad scope of knowledge and backgrounds provided an engaging and educational experience for all who attended.

They discussed topics which included heart health, cancer, reproductive health, the



difference in disease presentation in women vs. men, and much more. The panelists also stressed the importance of regular checkups with health care providers.

Thank you to Robert Braun, Knowledge is Power Chair, who not only moderated the panel, but also organized this successful Italian Sunday dinner event which helped raise over $1,000 for the National Ovarian Cancer Coalition.

WHAT'S NEXT IN HEALTHCARE REIMBURSEMENT?

Eric Lucas, Moss Adams
Richard Riter, Moss Adams
Melaney Scott, CIA, CHC, Moss Adams
Georgia Green, CHFP, Moss Adams

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

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

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

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

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

Effects of the Inflation Reduction Act

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

(continued on page 18)

ANNUAL CHAPTER GOLF CLASSIC

August 14, 2023

Thanks to all who attended and helped us raise $650 toward the HFMA Hawaii Chapter for Maui wildfire relief












HFMA METRO NY

4th ANNUAL VIRTUAL FOOD DRIVE

BENEFITING ISLAND HARVEST AND FEED AMERICA

We have raised over 6k lbs of food which equals over 5k meals.

LET'S MAKE THIS YEAR SPECIAL!

DONATE HERE

KILLING PATIENTS NOT GOOD FOR THE BOTTOM LINE

ERADICATING HEALTHCARE-ACQUIRED INFECTIONS AS A COST EFFECTIVENESS OF HEALTH STRATEGY

Bob Arnold, President, Arnold Standard Cos.; Independent Agent, The Klean Company

Healthcare-Associated Infections (HAIs) are linked with high morbidity and mortality, causing hospitals to incur tremendous costs: over 100,000 patient deaths and approximately $40 billion annually (i), which on average, translates to over $38,000 per bed.

Financial costs of HAIs include hard costs such as unreimbursed care, reimbursement penalties, litigation, increased insurance premiums, etc., as well as soft costs like lower quality ratings, reputational risk, goodwill, and lower workforce morale, which is especially troubling given the multitude of workforce issues the industry is currently facing.

The health costs range from an extra day in the hospital to permanent, catastrophic quality of life issues, including death, directly contradicting the credo of "do no harm."

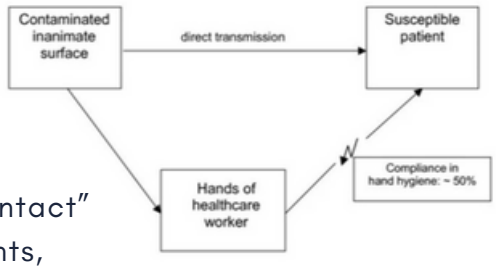
The finance function is playing an increasingly crucial role as the healthcare industry progressively shifts toward value delivery with a focus on service quality and patient satisfaction (ii).

"The future of healthcare is where quality impacts finance more than ever, and vice versa," according to Joe Fifer and Stephanie Mercado, former CEO of HFMA, and CEO of NAHQ, respectively (iii).

And finance leaders are in the perfect position to leverage their operational expertise to serve as catalysts for comprehensive performance improvement—a systematic approach to increasing overall value (iv).

On any given day, 1 in 31 hospital patients has an HAI, which are caused by the most serious antibiotic-resistant bacteria and fungi. But it doesn't have to be this way, as most HAIs can be avoided. The Joint Commission envisions a future of zero harm.

The biggest culprit in the spread of HAIs in hospitals is cleaning failure: of both surfaces and hands. Environmental surfaces, objects, and medical devices serve as colonization reservoirs for pathogens that can be transmitted by the hands of healthcare workers and visitors to patients. Poor hand hygiene has been implicated in 20-40% of HAIs. And alcohol based hand rubs are ineffective against many antimicrobial-resistance (AMR) pathogens, including Clostridium difficile spores.



Current "kill-on-contact" disinfectants, caustic chemicals that irritate the senses, are only working while they are wet, and many times are wiped off prior to drying on their own, diminishing their effectiveness against the spread of HAIs. And once they have dried, the treated area is immediately susceptible to recontamination.

But thanks to advances in antimicrobial technology, there are now products and services that deliver transformative, long-term protection against the spread of these

dangerous pathogens, and act as a surface barrier protectant that reaches full strength AFTER it dries, to help hospitals on their journey to zero harm (v).

These solutions are water- based, non-toxic, durable, EPA approved, and can be applied to surfaces, skin and fabric to create an active barrier that kills bacteria and fungi on contact AND for an extended period of time, which is extremely important given how long these pathogens can exist on inanimate surfaces (vi).

The active molecule has a stable molecular structure, which creates a microbial surface that consists of barbs (carbon chains) and a strong electrical field that attracts the bacteria and fungi to the treated porous and non-porous surfaces. When bacteria or fungi spores encounter this surface, the barbs puncture the cell wall rendering it harmless and/or the electrical field tears the cell apart.

They can be used in ALL areas of the hospital as they are below the minimum contaminant levels the FDA require for use on food contact surfaces. And corrosion is a non-issue as the molecule has been certified by Boeing for use on its aircraft.

HFMA's 2023-24 National Chair & CFO of Mayo Clinic, Dennis E. Dahlen, has declared "It's Time for Action!"(vii) I couldn't agree more when it comes to eradicating HAIs from hospitals.

How long do nosocomial pathogens persist on inanimate surfaces?

Pathogen	Duration of persistence (range)
Acinetobacter spp.	3 days to 5 months
Candida albicans	1 – 120 days
Candida auris	1 day to four weeks
Clostridium difficile (spores)	5 months
Enterococcus spp. including VRE and VSE	5 days – 4 months
Escherichia coli	1.5 hours – 16 months
Haemophilus influenzae	12 days
Helicobacter pylori	≤ 90 minutes
Klebsiella spp.	2 hours to > 30 months
Listeria spp.	1 day – months
Mycobacterium tuberculosis	1 day – 4 months
Salmonella spp.	1 day
Salmonella typhi	6 hours – 4 weeks
Salmonella typhimurium	10 days – 4.2 years
Staphylococcus aureus, including MRSA	7 days – 7 months
Streptococcus pneumoniae	1 – 20 days
Streptococcus pyogenes	3 days – 6.5 months
Vibrio cholerae	1 – 7 days

Eradicating HAIs - Lives Saved & Improved Economics

Sample Hospitals Using National Averages	Deaths/Cost based US hospital Averages/Yr			20% Lives Saved*	20% Savings Reduction*	Incremental Treatment Costs	ROI Multiple Potential
Facility	Beds	Est. Deaths	Cost of HAIs				
Hospital A	251	43	$ 9,641,060	9	$ 1,928,212	$ 200,800	10X
Haopital B	422	73	$ 16,209,272	15	$ 3,241,854	$ 337,600	10X
Hospital C	228	39	$ 8,757,616	8	$ 1,751,523	$ 182,400	10X
Haopital D	225	39	$ 8,642,384	8	$ 1,728,477	$ 182,400	10X
Hospital E	999	172	$ 38,372,185	34	$ 7,674,437	$ 799,200	10X
Haopital f	209	36	$ 8,027,815	7	$ 1,605,563	$ 167,200	10X
	2,334	402	$ 89,650,331	80	$ 17,930,066	$ 1,869,600	10X

*Studies indicate 81% incremental efficacy

Key Facts

Ave beds per hospital	151
Ave HAI loss per hospital	$5,800,000
Ave HAI loss per bed	$38,371
HAI Deaths per year	160,000
Ave HAI Deaths per hospital	26

Per Johns Hopkins May 2019 study

2,000 Ave Square Feet

Est. Claims Denied

MRSA 36,000	23%
C.diff 37,000	23%
Other 87,000	54%

(i) The Direct Medical Costs of Healthcare-Associated Infections in U.S. Hospitals and the Benefits of Prevention, https://www.cdc.gov/hai/pdfs/hai/scott_costpaper.pdf

(ii) HFMA & IMA Joint Study: Cost Management In Healthcare: Status Quo and Opportunities, https://www.imanet.org/research-publications/ima-reports/cost-management-in-healthcare-status-quo-and- opportunities?psso=true

(iii) Modern Healthcare Opinion, https://www.modernhealthcare.com/opinion/strategic-relationships-quality- finance-healthcare-joseph-fifer-stephanie-mercado

(iv) The CFO's Role in Accelerating Systemwide Performance Improvement, https://www.hfma.org/leadership/60856/

(v) Klean Company Hospital Study, https://www.thekleancompany.com/hospitalstudy

(vi) How long do nosocomial pathogens persist on inanimate surfaces? https://bmcinfectdis.biomedcentral.com/articles/10.1186/1471-2334-6-130

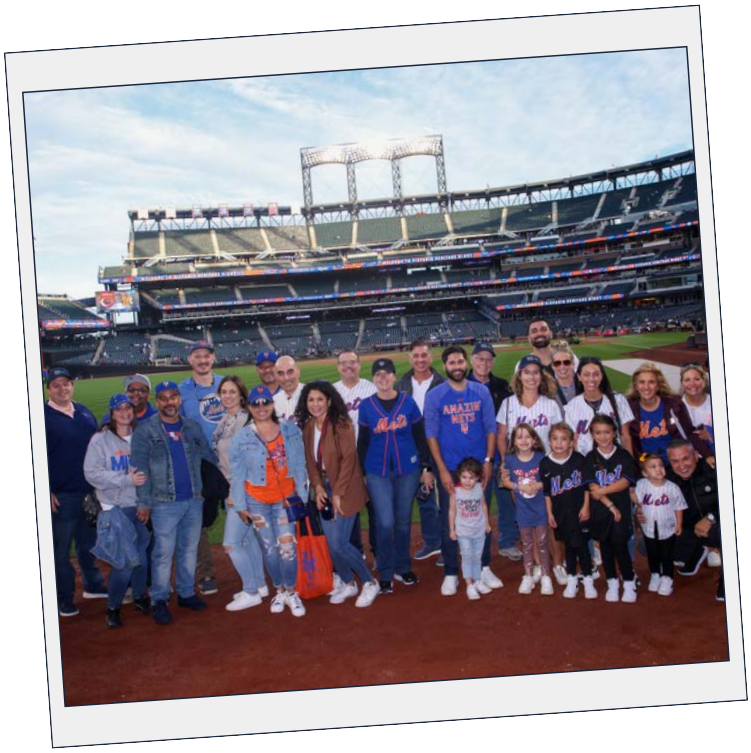
(vii) HFMA, It's time for action!, https://www.hfma.org/leadership/hfma-its-time-for-action/

FRIDAY NIGHT LIGHTS

September 15, 2023

The Metro NY Chapter celebrated the end of summer by inviting friends and family to an all-American tradition - a baseball game. Adults and children alike enjoyed watching the New York Mets take on the Cincinnati Reds for one of the last games of the regular season.

Thank you to Robert Braun for organizing this family friendly event for the second year.



VOLUNTEER

Volunteering for an HFMA Metro NY Chapter committee or event is a great way to get the most out of your HFMA membership. **It's Time to be a Chapter Leader!**

HFMA is a volunteer organization. Everything we do depends on the great group of people who give a little of their time and effort to make our Chapter a success. Whether you have an hour a week or a few hours a month, we would love to hear from you about your volunteer interests. Check out some of the areas where you can volunteer:

- **Registration/Membership:** Help us with member engagement and recruitment. Work with us on individual members, provider organizations, volunteer programs and member communications to ensure our members get the value they want. Help grow our Chapter!
- **Sponsorship:** Our Chapter relies on the great business partners that support us. Help us establish and maintain partnerships and deliver the results they need to see.

Interested in volunteering? Click here!

COST REPORT BASICS MEDICARE 101: INTRODUCTION TO THE COST REPORT UPDATE

September 28, 2023

The Cost Report Basics Medicare 101: Introduction to the Cost Report Update was held on Thursday, September 28, 2023, in-person at RSM US LLP in Times Square, with a virtual option for those who were unable to attend in person.

The event had 50 in-person participants and 30 virtual participants. We were successful in attracting some younger employees in the reimbursement space to the event, in addition to the regulars who typically attend the event, with a marketing emphasis on our pitch to CFOs and Directors of Finance as to why they should allow their staff to attend our event in person.

Sessions for the event included:

- Overview of the Medicare Reimbursement System
- Medicare Cost Report Settlement Components and the Wage Index
- Cost Report Overview and Worksheet Descriptions
- Medicare Cost Report 101 from a Legal Perspective
- Panel Discussion from Industry Leaders from our Health Systems

CELEBRATING THE LIFE OF PETER SIRIANI

PRESIDENT 1975-1976 AND VALUED HFMA MEMBER

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

REGION 2 ANNUAL FALL CONFERENCE

October 11-13, 2023

The Annual HFMA Region 2 Fall Conference was held in October at the Turning Stone Resort Casino in Verona, NY. Members from all four of the Region 2 chapters met for educational and social events over the course of three days.

Education sessions included subjects such as: Healthcare Accounting 101, improving employee retention, EHR systems, the customer revolution in healthcare, and the value of health care systems. Speakers

included Dennis Dahlen, HFMA National Chair and CFO of the Mayo Clinic; Louie Gravance, Former Disney Institute Professor; and Thom Mayer, MD, Medical Director of the NFL Players Association. Opening remarks were also made by Metro NY member Wendy Leo, Region 2 Regional Executive.

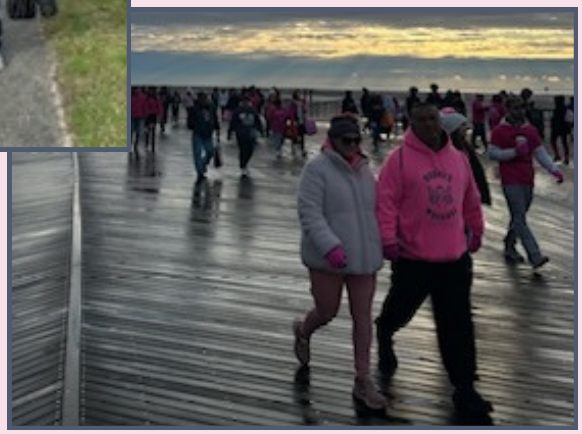
Though the weather was a little cold for golf, conference attendees were able to network at several social events, including a pirate-themed cocktail party.

MAKING STRIDES AGAINST BREAST CANCER

October 15, 2023

In October, HFMA Metro NY joined over 60,000 participants in the annual Making Strides Against Breast Cancer walk at Jones Beach. This event is a celebration of all things pink, and serves to raise awareness about breast cancer, honor the survivors and remember those who lost their fight.

The Metro NY team, led by Cathy Ekbom, Immediate Past President, more than doubled their fundraising goal, raising over $2,300 for the American Cancer Society. This funding helps the organization to save lives and support the future of breast cancer research, patient support and advocacy.



LOCAL NEWS

SCHOOL OF DENTAL MEDICINE HOSTS INAUGURAL DENTAL EDUCATORS DAY

Driven by the shortage of dental school faculty in New York and across the United States, Stony Brook School of Dental Medicine hosted its inaugural Dental Educators Day on Thursday, October 5, on Stony Brook University's south campus. The event was held in conjunction with World Teachers' Day, and will be celebrated at Stony Brook on the first Thursday in October each year.

Click here for more

MOBILE STROKE UNITS INCREASE ODDS OF AVERTING STROKE

Receiving a clot-busting drug in an ambulance-based mobile stroke unit (MSU) increases the likelihood of averting strokes and complete recovery compared with standard hospital emergency care, according to researchers at Weill Cornell Medicine, NewYork-Presbyterian, UTHealth Houston, Memorial Hermann-Texas Medical Center and five other medical centers across the United States.

Click here for more

NYU LANGONE HEALTH MARKS HISTORIC 75TH ANNIVERSARY OF RUSK REHABILITATION

To commemorate 75 years of innovation in physical and rehabilitation medicine, NYU Langone's Rusk Rehabilitation held a diamond anniversary recognition on September 22, during National Rehabilitation Awareness Week, to celebrate the groundbreaking concept of whole-person care developed by Howard A. Rusk, MD, during World War II.

Click here for more

FEINSTEIN INSTITUTES AWARDED $6.1M TO FUND BIPOLAR DISORDER PATIENT AND RESEARCH HUB

Researchers at The Feinstein Institutes for Medical Research received a $6.1 million grant from Breakthrough Discoveries for Thriving with Bipolar Disorders Foundation (BD2) to serve as a hub of six other sites across the country. Each site will evaluate patients and collectively offer the best treatment and clinical trial options using cutting-edge biotechnology, big data analytics and an unprecedented data ecosystem to address bipolar disorder in an innovative, equitable and rigorous way.

Click here for more

MAIMONIDES BREAST CENTER CELEBRATES BREAST CANCER SURVIVORS AT 10TH ANNUAL PINK RUNWAY FASHION SHOW

More than $525,000 raised to support patient care and continued innovation at Maimonides Breast Center, Brooklyn's first fully-accredited, award-winning Breast Cancer Center.

Click here for more

CATHOLIC HEALTH GOOD SAMARITAN UNIVERSITY HOSPITAL OPENS NEW DIABETES EDUCATION CENTER IN BAY SHORE

Catholic Health's Good Samaritan University Hospital (West Islip, NY) announced the opening of its new, outpatient Diabetes Education Center at 15 Park Avenue in Bay Shore. The new space will provide education for patients to better manage their diabetes.

Click here for more

CERTIFICATION

Why get certified? Because earning a certification validates your proficiency. And the benefits of getting certified range from higher salary to increased job fulfillment to improved organizational performance.

In addition to the Certified Healthcare Financial Professional (CHFP), HFMA also offers specialized certifications in **revenue cycle, accounting and finance, business intelligence, managed care, and physician practice management.** And, when you become a member of HFMA, all certification fees and study materials are included in your membership dues – that's whether you earn one or all of our designations.

HFMA partners with Credly to issue **digital badges** to all certified individuals which provides an easy way to share your designation through your email signature, LinkedIn profile, and more. You earned the designation and digital badging enables your ability to show off your accomplishment.

Explore HFMA certifications to determine the right path for you, your team, or your entire organization. Need assistance? **Click here** or contact **careerservices@hfma.org.**

FALL INSTITUTE

November 7, 2023

The Chapter's Annual Fall Institute was held on November 7th at UBS Arena. There were 130 attendees for this engaging educational event, over 50 of whom stayed to watch the NY Islanders vs. Minnesota Wild.

This year's event centered around innovation, the changing healthcare landscape, and finding new solutions to challenges in the industry. The keynote speaker for this event was Nio Queiro, CEO of the Queiro Group, who spoke about aligning mission with equity.

Additionally, there were panels on innovation (Betting on Healthcare Technology: The Innovators), ambulatory/urgent care (When Healthcare is Out of a Hospital's Reach), digital strategy (Gaining Market Share through a Digital Strategy), and a fireside chat entitled Navigating Healthcare Regulatory and Payment's Rough Terrain.

Thanks to Andrew Weingartner, President, and Alyson Belz, Vice President, for organizing this unique and memorable event.

(from page 5)

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

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

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

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

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

Transition to Value-Based Care

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

During the Future of Reimbursement with CMS discussion in January 2023, panelists Elizabeth Fowler and Meena Seshamani emphasized the Medicare Shared Savings Program (MSSP) is the main focus of implementing CMS's strategic plan. Health care providers want and need feedback from all stakeholders.

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

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

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

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

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

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

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

As mentioned, applications of VBC extend beyond ACOs. Some suspect the industry will continue to see population-based programs such as oncology bundles in the broader health care market. As reimbursement decreases, providers will turn toward such value-based changes to recover costs.

Key Takeaways

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

The Growth of Medicare Advantage

The Medicare Advantage (MA) program has seen exceptional growth over the past few

years, as roughly half of Medicare members are now enrolled in an MA plan. With these significant increases, there are several questions and implications, including around changing the benchmarks and transitioning MA to an ACO-driven model.

MA and MSSP Alignment

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

Value-Based Insurance Design

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

Star Ratings

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

MedPAC's Recommendations

What about changing the MA benchmarking methodology, something MedPAC has recommended? Presenters noted the predictability such adjustments would provide. But there are challenges to implementation and risks to moving too fast, they cautioned.

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

MedPAC's recommendations included payment cuts by at least two percentage points, although it could be more. The cuts are a result of the need for balance. There have been some specific cases where MA plans—which aren't all the same—have coded patient conditions and diagnoses more aggressively, due to incentives CMS didn't intend to create. That's why there's a gap between FFS and Medicare Advantage. The presenters expressed doubts the cuts would happen, noting the complexity of implementing benchmark changes.

Key Takeaways

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

Changes to Medicare Physician Fees

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

MedPAC representative Michael Chernew acknowledged physician fees are under-pacing inflation. MedPAC will be reporting in March 2024. Previous MedPAC meetings included discussion of recommendations around this issue. Chernew acknowledged the challenge in flat nominal physician fees and said stakeholders will need further discussion on that.

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

To offset the cost of paying more for E&M services, there was a cut in the conversion factor spread out over multiple years. It felt like a cut, however, for health care providers.

Cut or not, it's an area of great interest with an unclear future, though Chernew suspects there will be pressure on Congress to stall the payment changes. He added physician payments writ large will require attention beyond just these changes, including around telehealth.

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

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

Key Takeaways

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

Telehealth and Virtual Care

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

Remote Patient Monitoring

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

Administrative Burdens

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

These technologies make the case for broader payment models that don't require the administrative burden of delineating codes, according to Chernew. People messaging their providers raises the question of what constitutes care beyond the bounds of a visit? As telehealth grows, this must be addressed, and MedPAC is watching the issue.

Key Takeaways

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

There's also the issue of fraud. In light of warnings and fraud alerts from the Office of Inspector General (OIG), US Department of Health and Human Services, and others, providers should be cautious with telehealth billing of internal services as well as engaging third-party telehealth vendors. Assess and audit processes routinely and stay aware of state and federal policies and licensing requirements, which can be very different.

What Else We're Watching

Stakeholders should also pay attention to the following issues:

Traditional Medicare: Fee-for Service

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

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

Social Determinants of Health

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

Further, health equity measures will be introduced into the VBC payment determinations. Gathering SDOH data is

challenging, and hospitals should develop the supporting infrastructure, as this is likely to increase in number of metrics and financial impact in the coming years. With the influx of these changes, ensure you have people to keep track of the many moving pieces and break through departmental silos.

Site Neutral Payments

While more care continues to shift from the inpatient settings to outpatient settings and ambulatory facilities, Congress and CMS continue to review proposals that move toward site-neutrality payment methodologies for outpatient services. The overall impact could mean significant reduction to hospital Medicare reimbursement. Hospitals should consider these potential changes in their long-term strategic planning.

Medicare Cost Reporting

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

Acute care hospitals will face additional reporting requirements starting as early as next year that could impact reimbursement in a number of areas, including Medicare bad debts, Medicare DSH, Medicare DSH uncompensated care, and organ transplant reimbursement.

Medicaid Reimbursement

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

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

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

Medicaid Supplemental Payments

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

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

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

Prepare for Changes from Commercial Payers

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

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

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

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

■

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- Awards are for one year only and will require a new application each year to be considered for the scholarship.
- Members of the Executive Committee, the Evaluating Committee, their dependents and spouses are NOT eligible.
-

Applications will be weighted based on the following criteria:

- Essay 60%
- Community/Professional Experience 25%
- Field of Study 10%
- GPA of Most Recent
- Semester Completed 5%
-

For application scan here:

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Zachary Brody
Marie Louise Brutus
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Lisa Santiago
Ashay Shah
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Janette Vargas
Mingna Wang
Corinne Wyeth

Welcome

UPCOMING EVENTS

DATE / TIME	EVENT	LOCATION
Monday, November 21 1:00 - 2:00 pm	Webinar: Medicaid Eligibility, Recertifications and Asylum Seekers	Online
Wednesday, December 13 6:00 - 10:00 pm	Metro NY Holiday Party 2023	Cradle of Aviation Museum, Garden City
Thursday, January 18, 2024 6:00 - 9:00 pm	Winter Golf Networking Event	X-Golf, Westbury
Thursday, March 7- Friday, March 8, 2024	64th Joseph A. Levi Annual Institute	Long Island Marriott, Uniondale

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