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new jersey chapter
healthcare financial management association

Winter 2019 • vol 65 • num 2

garden state
focus
national excellence award winner

Where do we go from here?

- ACOs in New Jersey
- Clinically Integrated Networks
- Social Determinants of Health



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Who's Who in the Chapter	2
The President's View	
<i>by Erica Waller</i>	3
From the Editors	
<i>by Brian Herdman and Adam Abramowitz</i>	4
Hot Topics: ACO Formation	5
Who's Who in NJ	
Chapter Committees	13
Certification Corner	17
New Members	25
Focus on Finance	31
Job Bank Summary	32

Thank You from the NJ Sharing Network – 42nd Annual Institute Charity Event Beneficiary	7
Award-Winning Borgata Hosts 42nd Annual Institute	8
Addressing Social Determinants of Health: How Healthcare Organizations Can Act	14
Tis this Season to Protect Patients Against Viral Dangers	16
Is the EU General Data Protection Regulation Coming to a Hospital Near You?	18
Revenue Integrity Forum Hosts Successful 2019 Charge Master Update	21
The Clinically Integrated Network: A Value-Driven Organization Structure	23
Brugaletta v. Garcia – The New Jersey Supreme Court's Most Recent Decision on the Patient Safety Act	26
New Jersey's Exchange Enrollment Down, But That's Not The Whole Picture	29

Perspectives in Healthcare: 2019 New Year's Resolutions for CFOs	Inside Back Cover
---	--------------------------

Who's Who in the Chapter 2018-2019

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Half Page	\$ 800	\$ 720 / \$ 1,440	\$ 680 / \$ 2,040	\$ 640 / \$ 2,560

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OBJECTIVE

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

EDITORIAL POLICY

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

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The President's View . . .

Hello Everyone,

As President of the HFMA New Jersey Chapter, I would like to welcome you to the Winter Edition of the *Garden State Focus*. Time is certainly flying by and it is hard to believe that I am already halfway through my term. The second half of 2018 was filled with many wonderful events that wouldn't have been possible without the dedicated volunteers who donate their time to help lead this organization.

The last issue was dedicated to the 42nd Annual Institute, which was a great success. In addition to the education and networking opportunities provided, we were also able to donate over six thousand dollars to the NJ Sharing Network to aid in supporting their mission. Thank you all for your generosity! The Institute committee will start meeting again in January to plan the 43rd Institute and is always looking for new members.

The fall months also included several successful events including an online Excel training series, a Hot Topics in Healthcare Finance education session, and a networking event at Anthony's Coal Fired Pizza.

As I write this note, the Patient Financial Services and Patient Access Services Forums just finished their annual education session, which was very well received. Whether in person or online, these events take a lot of preparation. I can't thank our chapter leaders, committee members and other volunteers enough for providing our Chapter with nationally recognized education from industry leaders and experts!

Join us as we continue to follow the HFMA National theme and Imagine Tomorrow with these events planned for 2019:

- Join the NJ Chapter in supporting Special Olympics at the Seaside Polar Plunge on 2/23/19
- Annual Women's Session on 3/26/19 at the Doubletree, Tinton Falls
- 2019 Golf Classic at Fiddlers Elbow Country Club on 5/14/19

There are several other education and networking events being planned so please watch for updates in the weekly *Pulse* newsletter as well as on our website, www.hfmanj.org.

I hope everyone had a wonderful holiday season and that 2019 will be your best year yet!

Erica Waller

Erica Waller



Erica Waller



SAVE the DATE



Tuesday, March 26, 2019
The 2019 NJ HFMA Leadership and Development Session
 DoubleTree Hotel, Tinton Falls - Eatontown



Tuesday, May 14, 2019
Annual Golf Outing
 Fiddler's Elbow Country Club



October 2 – 4, 2019
2019 Annual Institute
 Borgata Hotel Casino & Spa

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

From The Editors . . .

Happy New Year to our HFMA Colleagues!

This Winter Edition of the *Garden State Focus* considers several important topics in the ongoing modernization of healthcare. Disease management and population health figure prominently in our content this issue. Articles on clinically integrated networks, social determinates of health, and best practices for flu season reinforce the concept that excellence extends beyond our experience in the fee-for-service world. 'Tis the season to pay extra attention to our health in the cold of winter.

Also in this edition, we begin an ongoing Hot Topics series that will consider broad national trends in our industry and ask prominent members of our community how those trends are felt locally. Our introductory article asks what factors may affect the formation of accountable care organizations. Thank you to Elizabeth Litten and Jane Kaye for sharing their thoughts with us.

For those who missed our Annual Institute last fall, John Dalton's summary on the three-day event is almost as good as being there. The Chapter contributed to the well-being of others in two ways this year: the Chapter's fundraiser for the NJ Sharing Network successfully raised funds for transplant support, and many of the Annual Institute attendees helped stuff care packages for the Atlantic City Rescue Mission. This element of service was a great addition to the Annual Institute agenda. Of course, our Chapter doesn't rest after the Annual Institute when it comes to planning education sessions. Kudos to the Revenue Integrity Forum for a great Charge

Master Update Session in December. Keep an eye out for more learning events this spring!

On a personal note – I hope you can join our Polar Plunge Team in Seaside Heights on February 23. Donate or sign up to participate here: <https://www.classy.org/team/202672>

About the Authors



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•Hot Topics: ACO Formation•

In this edition of the *Garden State Focus*, we are debuting our new Hot Topics column, where we ask health leaders across New Jersey to answer an important question that affects the New Jersey healthcare community. In this addition, we asked the following question to Elizabeth Litten (Partner and HIPAA Privacy & Security Officers with Fox Rothschild LLP) and Jane Kaye (Founder and President of HealthCare Finance Advisors):

As opposed to other areas of the country, New Jersey has not seen significant ACO formation. In your opinion why has the ACO model not taken off in New Jersey and do you think that this trend will continue?

Read their responses below:



Elizabeth Litten

applicable New Jersey licensing agency or board (for example, the Department of Health, Department of Banking and Insurance (DOBI), or, for certain mental health services, the Department of Human Services. The result is that New Jersey physicians are used to practicing independently and may be less likely to agree with or adhere to practice standards set by an ACO board. Second, New Jersey generally requires independent providers who join together for the purpose of contract-

The New Jersey regulatory landscape is unique in several ways that are likely contributors to the relatively slow proliferation of ACOs in New Jersey. First, New Jersey is one of several states that have what is often referred to as a “corporate practice of medicine” prohibition. In short, this generally means that corporate entities cannot run medical practices or provide or control the provision of healthcare services, unless the corporate entity is licensed by the

ing with carriers to become licensed or certified by DOBI as an Organized Delivery System.

New Jersey's geography and healthcare delivery system also present unique challenges that may impede ACO development and success. New Jersey providers are likely to serve patients who reside in New York, Pennsylvania, or Delaware who work in New Jersey or travel to New Jersey. In addition, although healthcare system consolidation has occurred at a rapid pace over the past several years, the number and density of hospitals located throughout the state has meant that patients may obtain services from multiple, independent providers – making the coordination of care more challenging, particularly when the independent providers' electronic health record systems do not communicate well.

Finally, New Jersey's healthcare reimbursement system has perversely incentivized the use of hospital emergency rooms and the election by certain specialists of out-of-network status. The recently enacted Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act may help shift the course this lumbering ship has been taking for the past decade and result in an environment more conducive to ACO growth.



Jane Kaye

New Jersey healthcare leaders have focused their efforts on the creation of these large health systems through the merger and

The healthcare landscape in New Jersey is different today than it was 10 years ago. A decade ago, New Jersey was home to dozens of independent hospitals that provided services to local communities. Today the state is defined by a few large health systems that provide services across multiple counties. Only a handful of independent hospitals and health systems remain.

acquisition process. The integration of independent entities into large health systems is a complex process. Implementation plans span several years as health systems work toward single processes across multiple sites and single-vendor technology solutions. The work effort to create these systems is significant and ongoing, requiring the allocation of human and capital resources that do not get deployed elsewhere.

This focus on the creation of large health systems is one explanation for why ACO formation has lagged behind other areas of the country. And with the continued fast pace of change in the healthcare industry, and multiple priorities competing for limited human and capital resources, it is likely that ACO formation will continue to lag behind other areas of the country into the near future.

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Thank You from the NJ Sharing Network – 42nd Annual Institute Charity Event Beneficiary

"We're honored to be selected as the beneficiary of this year's Charity Event. Thank you to HFMA for your generous support of our mission. The more than \$6,000 raised will ultimately help us to save more lives through innovative transplant research, family support, public awareness and education about organ and tissue donation and transplantation."

NJ Sharing Network is the non-profit organization responsible for the recovery and placement of donated organs and tissue for those in need of a life-saving transplant. Nearly 4,000 New Jersey residents are currently awaiting transplantation. We are also part of the national recovery system, which is in place for the 115,000 people on the national waiting list.



Dear Sandy, Mike + the Annual Institute Committee,

Thank you so very much for including NJ Sharing Network in the 42nd Annual Meeting. We were honored to be chosen as the beneficiary for the charity event and we're overwhelmed by the generosity of your members. What a terrific program! Thank you again for the opportunity.

Amanda & friends
at NJ Sharing Network

Our Foundation is committed to increasing the number of lives saved through innovative transplant research, family support, public awareness and education about the life-saving benefits of organ and tissue donation and transplantation.

Award-Winning Borgata Hosts 42nd Annual Institute

by John J. Dalton, MBA, FHFMA



John J. Dalton

Co-sponsored by the Metropolitan Philadelphia and New Jersey HFMA Chapters, the 42th Annual Institute's 2-1/2 days of educational sessions was held October 3-5 at the award-winning Borgata Hotel Casino & Spa. Named the 2018 "Property of the Year" during the Global Gaming Awards at this year's Global Gaming Expo, the Borgata has been the Annual Institute's venue of choice for much of the past 15 years since its opening.

More than 400 members of the New Jersey and Metropolitan Philadelphia Chapters turned out to "Imagine Tomorrow," collecting CPE credits and searching for at least one takeaway to help them in their work. Opportunities for finding that next great idea abounded, both in the nine general sessions, the 34 breakout sessions, the two Lunch & Learns, and at vendor booths. The Institute also featured a successful fundraising event Wednesday evening for The Sharing Network, a jam-packed President's Reception Thursday evening in the Central Conference Center, and a late-night gathering at the Premier Nightclub.

Imagine Tomorrow



HFMA National Chair Kevin Brennan opened the Institute by briefing attendees on his vision for HFMA members, challenging them to "Imagine Tomorrow" as their organizations strive to achieve the Triple Aim. Recently retired from Geisinger Health System, Mr. Brennan served for 23 years as Executive Vice President of Finance and CFO, becoming the longest-serving CFO in Geisinger's

103-year history. A member of the Metropolitan Philadelphia Chapter since 1992, he now serves as a Principal at SunStone Consulting.

Mr. Brennan outlined current HFMA initiatives designed to help finance professionals in their efforts to make a difference in today's healthcare industry. He emphasized the need to overcome barriers to consumerism, and described HFMA's consumer resources, including "Patient Financial

Communications Best Practices." Noting that business models are evolving faster than their associated operating systems, Mr. Brennan stated that the finance function will be radically different ten years from now. He concluded by summarizing HFMA's contemporary learning and professional development strategy, including HFMA Compass, issued twice weekly since August 1.

Following Mr. Brennan's presentation, Colleen Picklo, Deputy Director, Managed Care and Insurance at the New Jersey Hospital Association (NJHA), and Tracy Lutz, Managing Partner, Specialized Healthcare Partners, LLC, provided guidance on complying with New Jersey's "Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act." Signed June 1 and effective August 29, the OON Act is the culmination of years of efforts to help consumers avoid "surprise bills."

The Act's provisions are extensive and add a layer of complexity to provider administrative processes that is likely to increase costs without necessarily providing any benefit. The Act requires general acute care hospitals, satellite emergency departments, hospital-based off-site ambulatory facilities that perform ambulatory surgical procedures, and ambulatory surgery facilities to provide certain information to consumers, including making available to the public a listing of the facility's standard charges for items and services provided in a form that is consistent with federal guidelines.

Although the law provides consumer protections that NJHA has long supported, it is important to recognize that the law impacts consumers differently based on the type of insurance they have. The only plans definitively covered by the law are health plans that are fully insured and issued in New Jersey, as well as the State Health Benefits Plan and the School Employees' Health Benefits Plan. In the case of a self-funded plan, the plan sponsor may opt in and elect to subject itself to the law; however, it is not required to opt in. Therefore, the only provisions of the law that apply to members of self-funded plans that have elected not to opt in are disclosure and arbitration requirements. NJHA has developed a toolkit to assist providers in implementing the Act's requirements that includes:

- **Provider Website Requirements:** A checklist of the information that must appear on a hospital's website including sample language to accompany the postings.
- **Patient Notice Requirements Checklist and Script Language:** A checklist of information that must be shared with a patient when scheduling an appointment, and customizable script to assist with ensuring that specific information is discussed.
- **Appeal Resources:** A checklist for filing out-of-network claim appeals under the new law including a sample notice to the Department of Banking and Insurance initiating arbitration.
- **Voluntary Out-of-Network Selection Acknowledgement:** A form that may be shared with patients that knowingly and voluntarily choose to use an out-of-network provider.
- **Patient Disclosure Notices in both English and Spanish:** Forms that may be shared with patients to acknowledge that the required disclosure information was shared.
- **Physician Awareness Message:** A summary of the law that may be shared with the provider's employed and contracted physicians to notify and inform them about the law's provisions.
- **Media/Community Talking Points:** Suggested talking points that may assist in informing and educating local media and community representatives about the law.
- **Consumer Resources:** Assisting consumers with understanding medical bills, including "Putting the Pieces Together: Your Step-by-Step Guide to Understanding Your Medical Bills," and "Putting the Pieces Together: Your Guide to Surprise Medical Bills."

NJHA will continue to furnish guidance to providers as implementation continues.

Wednesday afternoon's general sessions concluded with a presentation by Amanda Tibok, Senior Manager, Philanthropy and Foundation Programs for the New Jersey Sharing Network. Located in New Providence, it covers 14 counties in North Jersey and was the beneficiary of the Institute's Wednesday evening charity fundraiser. Ms. Tibok described the network's services, noting that roughly 550 organs are recovered each year in New Jersey. Organs used include heart, liver, lung, kidney, pancreas and intestines. Tissue donations include corneas, valves, bones, tendons, veins and skin. A single organ donor can save eight lives and tissue donations can have a positive impact on more than 75 lives. In a "show of hands" survey, more than half of the attendees were registered as organ donors.

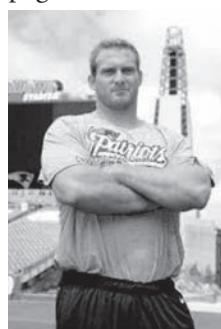
Unfortunately, last year more than 100 New Jersey residents died while awaiting a compatible donor organ. Ms. Tibok thanked HFMA for its support and encouraged all in the audience to register as organ donors.

Thursday's General Sessions

Immediate Past President Scott Mariani opened Thursday with the Annual Chapter Awards Presentation. The New Jersey Chapter garnered a total of six Helen M. Yerger Awards during the June 1, 2017 – May 31, 2018 year. The Yerger awards recognize outstanding Chapter performance in the categories of Education, Collaboration, Improvement and Innovation, and were presented at the Annual National Institute (ANI) in June. See page 61 of the Fall issue of *Garden State Focus* for photos from the ANI. The following awards were received:

1. Education – Education Roadshow – three complimentary CPE credits at NJ healthcare systems. Recipients: Sandy Gubbine and Scott Mariani.
2. Collaboration – Compliance Program jointly with NJHA. Recipients: Mel Sponholz, Rob Senska, Lisa Weinstein, Angela Melillo.
3. Improvement – Form an Investment Committee. Recipients: Tony Panico, Mike Costa, Mike McKeever.
4. Innovation – Speed Networking. Recipients: Deb Carlino, Heather Weber.
5. Multi-Chapter Yerger with Region 3 Chapters – R3 Webinar Program. Recipients: Guy Hoffman, Scott Mariani.
6. Multi-Chapter Yerger with Philadelphia Chapter – New Jersey/Philadelphia Annual Institute. Recipients: Scott Mariani, Mike McKeever.

Mr. Mariani also presented the individual Chapter Awards. Recipients were listed in the Fall issue of *Garden State Focus* on page 41.



Ben Bartholomew, Regional Vice President of Business Development for InstaMed, inspired the audience with a look at "Leadership the Belichick Way." A Nashville native, Mr. Bartholomew played college football at the University of Tennessee, then signed with the New England Patriots. Contrasting top athletes with employees, he noted that all top athletes have four qualities:

1. Humility
2. They seek feedback daily
3. They start every day at zero
4. They have an insatiable appetite for learning

In a presentation filled with anecdotes about the winning culture of the Patriots under Coach Belichick, Mr. Bartholomew concluded by summarizing the core of the Patriot Way as follows:

- How can you help the team today? It's not about how much you know, but how fast can you learn?
- Love the game/job. You must be willing to put in the work and buy into the program.

continued on page 10

continued from page 9

- Respect the opportunity you have and be humble.
- Above all, be dependable.

Dr. Ronald Hirsh, Vice President at R1 RCM, Inc., provided attendees with an illuminating Medicare update. Topics covered included the bundled care payment initiative, changes to the inpatient-only and ASC lists, admission order authentication for Part A billing, Two-Midnight Rule adherence, and new coding for the social determinants of health. A related article by Dr. Hirsh can be found at page 37 of the Fall issue of *Garden State Focus*.

Urging attendees to "Fire Up Your Life," Thursday morning's final speaker, Donna Hartley, walked the audience through her inspiring life story, living through a DC-10 plane crash, surviving a stage 3 melanoma diagnosis and the emergency replacement of a faulty aortic valve. A graduate of the University of Hawaii and former Miss Hawaii (on her fifth try), Ms. Hartley has been featured on PBS, NBC, ABC and written about in the *New York Times*.

Noting that "everything happens for a reason," she encouraged attendees to say five positive things about themselves first thing in the morning. "Success is 87% attitude, 13% skill." Her fact-filled message was both inspirational and entertaining.



Friday's General Sessions

Leadership is a Mindset



Tim Connor, President and CEO of the Peak Performance Institute, gave Friday morning's audience a wake-up call with his rousing call to leadership. Noting that there are more than 350 definitions of leadership, Mr. Connor made it clear that leadership is neither a title nor a position, but rather a mindset. It's not the product or service that puts organizations out of business; it's poor leadership.

"Real leadership is about a personal vision to excel regardless of roles or responsibilities." His advice on management basics include:

- You get the behavior that you reward
- Give authority along with responsibility
- Hold people accountable

- Employees want more recognition, appreciation, feedback and to be trusted
- Inspect what you expect
- You are responsible to people, not for them

More of Mr. Connor's advice on leadership can be read beginning at page 34 of the Fall issue of *Garden State Focus*.

C-Suite Panel

The Institute's Friday general sessions have traditionally included a C-Suite Panel, usually comprised of CEOs or CFOs. Given the increased emphasis on technology-driven approaches to improving both patient care and patient experience, this year's panel focused on information technology. Moderated by Joe Carr, Vice President and Chief Information Officer (CIO) at NJHA, panelists included CIOs Tom Gordon, Virtua; Christopher Scanzera, AtlantiCare; CFO Guilherme Valladres, Penn Medicine Princeton; and consultant Vishal Suchdev of Ernst & Young.

Mr. Carr had the panelists introduce themselves and briefly highlight their challenges and opportunities. Currently, the two predominant electronic medical record organizations (Epic & Cerner) found their business model/opportunity in the clinical space with the advent of computerized physician or patient order entry systems (CPOE) before the HITECH Act poured billions of dollars into electronic health record implementation. Noting the incredible churn in New Jersey's information systems marketspace over the last three to five years (e.g., from a predominantly Siemens state to what now appears to be a predominantly Epic state), he asked the panelists to describe their current financial system or what they will be transitioning to soon.

Questions addressed by the panel included:

- How long did this take once the contract was signed until you were fully live and dropping bills?
- What was your biggest hurdle to get over during implementation?
- Did you run parallel with the new and the old system prior to "go live?"
- Was cash flow impacted by your transition?
- Are you and your patient financial services (PFS) managers happy with the new system and do you feel you are better off now? Please tell us why it's better or worse than your prior system.
- Was it easy for your PFS Staff to learn and please share how much training was required to get everyone to the point where they could do their job?
- How much customization if any did it take for you make the new financial system work for your PFS Team?
- How did this impact your EDI Vendor? Did it replace

the need, or did you keep the same EDI post bill drop vendor to scrub and deliver your 837s?

- If you were to give your colleague at another organization advice about transitioning to another financial system, what would that advice be?

The panelists provided a wealth of insights and advice that should be helpful to finance professionals adapting to changing information systems.

Managing Cybersecurity Threats

Appropriately, the Institute concluded with an alarming presentation on cybersecurity risks and threats by Robert Olsen, Senior Managing Director at Ankura. Mr. Olsen's illuminating talk covered threat trends, threat actors and methods; a risk-based approach to data security; and HIPAA security rule compliance.

Mr. Olsen described the principal threat actors (e.g., negligent insiders, malicious insiders, criminal hackers, nation states) and various attack methods (e.g., phishing, spear phishing, malware, etc.).

His risk-based approach to data protection begins with a cybersecurity risk assessment/audit to identify vulnerabilities

and gaps. Next, he develops a security road map based on threats and assessment findings.

Mr. Olsen concluded his presentation with the following summary:

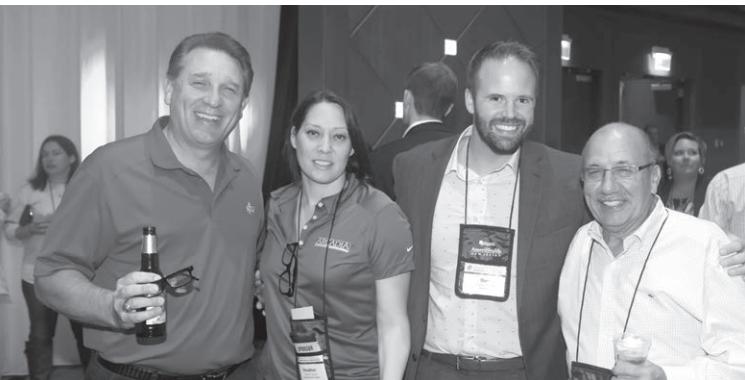
- Hackers are growing increasingly sophisticated and patient.
- Humans continue to be the weakest link
- Cloud-based applications present unique challenges for organizations
- A risk-based approach should drive your organization

Mr. Olsen's article, "Cybersecurity and the Risks to Healthcare Privacy," can be found at page 12 of the Fall issue of *Garden State Focus*.

About the Author:

John J. Dalton, FHFMA, Senior Advisor Emeritus at BESLER, is a former Chapter President, National Board member, and HFMA's 2001 Morgan Award winner for lifetime achievement in healthcare financial management.





•Who's Who in NJ Chapter Committees•

2018-2019 Chapter Committees and Scheduled Meeting Dates

*NOTE: Committees have use of the NJ HFMA conference Call line. **The call-in number is (515) 739-1015**

If the committee uses the conference call line, their respective attendee codes are listed with the meeting date.

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

COMMITTEE	PHONE	DATES/TIME/ ACCESS CODE	MEETING LOCATION
CARE (Compliance, Audit, Risk, & Ethics)			
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Chairman: Lew Bivona – ldbcpa@verizon.net	(609) 254-8141		

Addressing Social Determinants of Health: How Healthcare Organizations Can Act



by Andrew Snyder and Anita Cattrell

Andrew Snyder

Years of research and data have shown that social determinants of health have a significant impact on the profitability and sustainability of the healthcare industry. In fact, when considered broadly across racial disparities, education, social support, transportation, healthy food and poverty, social determinants of health have been shown to account for more than a third of total deaths annually in the United States, and up to 60% of healthcare costs, eclipsing actual direct medical expense. This is most likely attributed to the imbalance of medical and social spending in the U.S. On average, nations that are members of the Organization for Economic Cooperation and Development (OECD) spend about \$1.70 on social services for every \$1 on health services; the U.S. spends just 56 cents.

To correct this imbalance, we need to shift a portion of our current healthcare expenditures to investments that address upstream social factors that heavily influence downstream outcomes. Evidence suggests that addressing social determinants of health is not only important for improving overall health, but also for reducing health disparities that are often rooted in social and economic disadvantages. For example, in addition to lower body mass index and fewer risk factors for chronic disease, early childhood education has been associated with higher levels of education attainment and income and lower rates of violent crime and incarceration.

Given the far-reaching impact of these efforts, the return on investments addressing social determinants accrues not only to the health system in the form of reduced healthcare expense, but also to the broader community. However, current financing structures make it challenging for public sectors to pool resources together and measure the “full” return of these investments, which consist of capital infusion, tools and community-level mechanisms to deliver services. Most provider organizations don’t have the means to make these

investments on their own, and those that have the means will likely find it difficult to see a near-term monetary ROI, as downstream efforts require time to take effect and may be extended beyond the healthcare system.

Pushing Forward by Working Backward

Until a broader community impact can be measured, health systems will need to be thoughtful and targeted on where and how they invest in social determinants of health to ensure a positive ROI. By developing approaches that work backward from the outcome they’re trying to change, health systems can take progressive steps toward targeting the underlying causes of these issues, rather than siloed steps that treat only symptoms.

Some of the cursory discussions of social determinants of health suggest that addressing single factors can have a large impact on outcomes. Although analysis shows this not to be true, most organizations are still tackling these issues in a silo. For example, we’ve seen evidence that providing free transportation services to Medicaid patients does not decrease missed primary care visits, and that building grocery stores in food deserts does not alter dietary habits.

One big reason why these interventions are not having an impact is that they are not targeted at those who would benefit most. Another reason is that they frequently lack an agreed-upon point of accountability for integrating these social services into the broader healthcare planning for these individuals. For example, through our own analysis, we know that for a specific set of individuals, having a transportation



Anita Cattrell

barrier is associated with a 63% increase in risk of readmission. However, providing just a ride for those patients isn't enough. There needs to be a coordinated effort, with a medical professional visiting the home and ensuring that the conditions are conducive to a successful recovery. This includes making sure that the patient has a follow-up visit with his or her physician; conducting a comprehensive medication review; and ensuring that the individual has the support he or she needs to obtain and adhere to the prescribed regimen to avoid a readmission.

But without someone taking accountability for coordinating this transportation service with all the other services needed, the chances of avoiding a readmission are low. It's the diffuse responsibility that's led to symptom-focused and ineffective solutions, and that's what needs to change to see widespread impact and an actual ROI on these types of investments.

When accountability is present, however, a chain of connections answering to one another can help identify overall goals that can be approached in a concerted way. The team can work backward from there to drive forward progressive steps toward bigger goals and address social determinants of health in ways that show marked impact on health outcomes. To help ensure that social determinants of health efforts are accountable and productive, healthcare organizations can use these three action steps as a guide:

1. Define accountability. As a care team comes online, it will need a leader — one who is not necessarily responsible for addressing individual social determinants, but who is accountable to the patient for the results. Primary care physicians — already the “quarterbacks” for their patients’ care and accountable for total cost of care in new payment models — are perfectly positioned for this role. To succeed, though, these quarterbacks must have a strong team behind them, consisting of dedicated clinicians who are integrated into a care delivery team and who themselves are empowered to advocate for change, act on data-informed recommendations and coordinate or monitor interventions within and without the healthcare provider.

2. Use AI and machine learning to create and follow a comprehensive map. To change a patient’s health status and trajectory, one needs a clear understanding of where the patient is headed, what’s pushing him or her in that direction and what are the roadblocks to better paths. Can patients easily access a store that sells food appropriate to their recommended diet? If told to come in for a follow-up, can they make time during the day, or are they a sole caregiver for a disabled relative?

Disparate data sets can shed light on neighborhood food, public transit access, household type, education, financial

history, clinical notes from the electronic medical record, and other variables. When these data sets are aggregated, artificial intelligence and machine learning can flag variables that, when viewed together, can pinpoint both clinical and social risk factors and flag opportunities for either physician or community intervention. Such machine-learning resources can be designed to provide push-notifications and other interactive support tools that convert data sets into actionable insights while minimizing any additions to administrative time.

3. Redefine your measurement strategy by collaborating across stakeholders on shared goals. Realizing an ROI is challenging when the investments made affect patients from multiple touchpoints. Metric definition and metric measurement, like interventions themselves, need to extend beyond a care provider’s four walls. Work that has traditionally been done purely at the social level should now be married with health and outcomes data to predict areas of need and define success in a more robust manner. Considerable barriers remain as clinicians who answer to their own facility’s balance sheets must make a case to financial overseers, who may not be willing to count a community benefit as a realized return. We may need to see new public discussion on tax exemption and definitions of community benefit here. But there’s strong potential, if we get it right, to redefine managed care and community health if we can further redefine the metrics of care outcomes.

About the Authors:

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Tis this Season to Protect Patients Against Viral Dangers

by Shannon Davila, MSN, RN, CIC, CPHQ



Shannon Davila

This time of year many of us are taking steps to keep our homes warm for the winter or maybe planning ahead for spring vacations. While we are busy doing that, healthcare facilities are preparing for the threat of danger to their patients, visitors and staff that comes in the form of viruses.

Viruses are small infectious agents that cause a wide range of illnesses. Different from bacteria, viruses are smaller and cannot be cured with common antibiotics. Viruses can be transmitted through the air, by touching contaminated surfaces or from direct person-to-person contact. Viruses circulate around us all year, but some viruses, like influenza, have a more predictable season in which they occur. The good news is that with good planning and preparation healthcare providers can take actions to help prevent the spread of viruses to patients, visitors and staff.

Adenovirus

Adenoviruses are a group of viruses that circulate all year long and can cause a wide range of illnesses such as pneumonia, the common cold, sore throat, diarrhea, and conjunctivitis (pink eye). This virus is usually spread from person-to-person contact, like shaking hands, or spread through the air by coughing and sneezing (CDC, 2018). Adenoviruses can also live on environmental surfaces and can be spread by a person touching a contaminated surface then touching their mouth or eyes.

Adenoviruses most commonly cause respiratory illness, including pneumonia and bronchitis. Although most cases of adenovirus are mild, people with weakened immune systems or existing respiratory or cardiac disease are at higher risk of the illness progressing into more severe stages.

Outbreaks of adenovirus have been documented in healthcare settings that provide care for patients with severe existing illness or conditions and weakened immune systems (NJ-DOH, 2018). Due to the high risk of severe illness in these patient populations, healthcare providers must be vigilant in their assessment of adenovirus and their actions to prevent transmission.

Protecting patients and staff

Currently there is no vaccine available to the public to protect against adenovirus. Within healthcare settings, healthcare providers should carefully assess patients for signs and symptoms of adenovirus and alert public health authorities if an outbreak occurs. Unlike bacterial infections, there is no specific treatment for people with adenovirus infections. According to the CDC (2018), most adenovirus infections are mild in nature and patients may only need minor treatment to manage their symptoms. However, depending on the health status of the infected person, the infection could become severe and require more intense supportive therapy.

Healthcare providers should be alerted to patients that are confirmed or highly suspicious of being infected with adenovirus, and they must put the necessary infection prevention precautions into place. This would include using personal protective equipment like gloves, gowns and masks to reduce the risk of transmission. Frequent hand hygiene is another important barrier to the spread of this and all other viruses. Additionally, environmental cleaning should occur, such as using a disinfectant product that is approved to kill adenovirus.

Influenza

Influenza, also known as the “flu,” is another virus that can cause mild to severe illness. Influenza typically strikes in the fall and winter months and can cause different symptoms including fever, chills, cough, sore throat, runny nose, body aches, and fatigue. Usually, healthy people will experience symptoms for up to two weeks and will not require additional medical treatment beyond rest and hydration.

Anyone can become sick with influenza, but those most at risk of severe illness include people 65 years and older, individuals with chronic medical conditions like asthma, diabetes, or heart disease; pregnant women; and very young children, especially those younger than two years old (CDC, 2018). Those individuals at higher risk may experience more severe illness or develop complications like pneumonia. Sometimes these complications can be life threatening; this is why healthcare

providers must actively promote strategies to reduce exposure and transmission of influenza.

Protecting patients and staff

Healthcare facilities can help prevent the spread of influenza by promoting vaccination among patients and staff. Due to the changing genetic makeup of the virus on an annual basis, the influenza vaccine must be administered every year to promote effective immunity. In addition to vaccination, people with influenza should stay home when sick, practice strict hand hygiene and cover their coughs and sneezes. When patients infected with influenza are admitted to healthcare settings, infection prevention precautions must be put into place, like staff and visitors wearing masks.

In summary, viruses are all around us, but there are actions that we can take to reduce the risk of illness. Healthcare providers should implement these actions and with good preparation can help improve the care and safety of patients, families, visitors and staff. To learn more or get further information and resources about both influenza and adenovirus please visit New Jersey Hospital Associations website <http://www.njha.com/quality-patient-safety/public-health-issues/>.

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About the Author:

Shannon serves as the Director of the New Jersey Hospital Association's Institute for Quality and Patient Safety and Clinical Director of the New Jersey Hospital Improvement Innovation Network. She can be reached at SDavila@NJHA.com.

•Certification Corner•

It is each that time of a year when we need to think about Certification Maintenance!

HFMA members who have earned either the Certified Healthcare Financial Professional (CHFP) or Fellow of HFMA (FHFMA) designation must maintain their certification every three years by meeting two basic requirements:

- Remain an active HFMA member in good standing
- Complete 60 hours of eligible education activities every three years

Continuing education activities eligible for certification maintenance include, but are not limited to the following:

- seminars
- conferences
- workshops
- educational offerings sponsored by employers
- webinars
- e-learning self-study courses

It is each member's responsibility to self-report education hours/activities using the online reporting tool. The only educational activities that do not need to be self-reported are activities sponsored by HFMA National for which members

have received CPE credit. Access to the online reporting tool is available only to current CHFP/FHFMA-certified members and login is required.

HFMA members who have earned either Certified Revenue Cycle Representative (CRCR) or Certified Specialist (CS) certificates must maintain their certification every two years.

The recertification process is straightforward: to re-certify as a CRCR or CS, members must take a 50-question online exam. To help prepare for the exam, the updated e-learning course is available. The cost of the CS and CRCR recertification exams are \$100.

The recertification e-learning course and exam are available for purchase five months in advance of certificate's expiration date (the expiration date is always 5/31/XX). Recertification programs must be completed prior to May 31. In January of the year of eligibility, members will receive a reminder email that includes the link to purchase the recertification e-learning course materials and exam. Only members eligible for recertification are able to purchase materials.

If you have any HFMA maintenance questions, please contact Amina Rasanica at arasanica@njha.com or call HFMA Career Services at (800) 252-4362 ext. 311.

Is the EU General Data Protection Regulation Coming to a Hospital Near You?



by Odia Kagan, LLB, LLM, FIP, CIPM, CIAPP/US, CIAPP/E, CDPO

Odia Kagan

The General Data Protection Regulation (GDPR), a comprehensive law protecting information that identifies individuals in the European Union (EU), went into effect on May 25, 2018 and is said to be the most groundbreaking privacy law in recent times. With detailed disclosure requirements, extensive rights to individuals to control how their personal information is used, and fines reaching 4% of worldwide revenue, companies have been forced to rethink some of their data processing practices.

But what about me, you ask? Could a hospital, or other healthcare (or healthcare IT) provider, based in New Jersey be caught in the net of the GDPR? And if so, what does that mean for me?

1. Does GDPR apply to all companies? No

GDPR only applies to companies that collect or otherwise handle ("process") information that identifies living individuals ("Personal Data"). In the case of companies that do not have an establishment in the EU, GDPR will only apply if the company collects or processes information that identifies individuals that are physically located in the EU.

Therefore, GDPR could apply to you if you are processing Personal Data of EU-based employees, EU-based healthcare providers (for example, in the context of clinical trial sites), EU-based patients or EU-based customers of your medical device or healthcare IT service.

2. Does GDPR apply only to PHI or medical data? NO

The definition of "Personal Data" under GDPR is very broad and includes information that identifies, or could reasonably identify, individuals. This includes the "usual suspects" like name, address, and medical information, but also includes online identifiers, such as IP addresses and mobile device identifiers. It is also important to note that hashed or coded information (as used in the course of clinical trials) is also generally considered "Personal Data" and still is within scope for GDPR.

3. Does GDPR apply to US-based companies? Yes, sometimes.

GDPR applies to companies that: (i) have an establishment in the EU, (ii) offer products or services to individuals in the EU, or that (iii) track or monitor the behavior of individuals in the EU. What does this mean?

(i) Establishment in the EU –

This could clearly include a subsidiary or branch in one or more EU member states, but could also mean a joint venture arrangement or even a single employee or agent in the EU. Just having a website that is accessible from the EU is not enough to constitute an establishment.

(ii) Offering Products or Services in the EU –

This could cover you if you are a B2C, dealing directly with individuals in the EU through an e-commerce website, for example, or if you offer a service, including an unpaid service, such as research or information online to individuals in the EU. It could also apply to telemedicine services or other medical services if they are considered to be offered to individuals in the EU (e.g., specialized services marketed to EU individuals, medical tourism).

In order to fall within the scope of GDPR, a business would need to manifest its intention to establish commercial relations with customers in the EU. How this intention will be interpreted, however, is unclear and the GDPR does not provide any minimum threshold for number of customers or users from the EU. Recent draft guidelines from EU regulator, the European Data Protection Board (EDPB), provide a non-exhaustive list of criteria that may apply:

- Designating one or more EU member states with reference to the goods or services in your publications or materials
- Paying a search engine operator for an internet referencing service to facilitate access to your website by consumers in the EU

- Marketing and advertising campaigns directed at an EU country audience
- An international nature of activity at issue
- Mentioning dedicated addresses or phone numbers to be reached from an EU country
- Using an EU or member state top level domain URL (e.g., .de or .fr)
- Mentioning an international clientele, composed of customers living in various EU member states, including client testimonials from EU residents
- Using an EU language or taking EU currency
- Offering the delivery of goods in EU member states

The EDPB Guidelines also state that old competition EU case law discussing “directing activity toward” the EU should apply. Those cases also consider the actual number of existing EU customers or users as a test.

(iii) Monitoring or Tracking Behavior of Individuals in the EU

Monitoring can be done both on the internet or through other types of network or technology involving personal data processing like wearable or other smart devices.

Here, you do not need to have any intention to target the EU in order to fall in scope. Therefore, if you have a robust tracking or analytics scheme on your website, this may be considered “monitoring.” The recent EDPB Guidelines state that while not every collection or analysis of personal data would automatically be monitoring, the purposes of the processing and analysis would need to be considered.

Some monitoring activities listed by the EDPB include:

- behavioral advertising
- online tracking through the use of cookies
- personalized diet and health analytics services online
- market surveys or behavioral studies
- monitoring or regular reporting on an individual's health status

4. So if I don't deal with individuals directly, GDPR will never apply to me? Not exactly

If you are a U.S.-based company that provides services to another company that is subject to GDPR, you may need to comply with the requirements of GDPR *in practice* because your client company is required to flow down its obligations under GDPR down its supply chain.

If you are a subsidiary or part of a group of companies of which some are subject to GDPR, you will likely need to address at least some GDPR compliance as part of the efforts of the parent or sister companies.

If you are a U.S.-based company that uses service providers subject to GDPR, that will not, by itself, subject you to GDPR, but you should expect to receive requests to amend the agreements with these providers to in a way that allows them to comply with their obligations under GDPR.

5. But I have to process personal data of EU individuals, does GDPR mean I have to stop? No

GDPR does not prohibit the processing of personal data. It may, however, require some rethinking of how you process data and how you treat individuals.

6. I think I may be in scope for GDPR – what should I do now? Keep calm and make a plan

Some steps you can start with are:

- Map your personal data:
 - Assess where your data is coming from – is it directly from the individuals? Through a third party?
 - You would also need to understand why you are collecting the data, how you are using it, where is it stored and to what end.

This is the only way to know the scope of compliance work you would need to do.

- Map your third-party providers/data transfers and enter into the necessary agreements:

- Who are the third parties with whom you share personal data (this includes intra-company transfers to sister companies or subsidiaries).
- Do you use any service providers to handle any part of the processing of data? (This includes storage, mailing, CROs, sales representatives, healthcare providers, any third-party services that interact with your patients' or customers' electronic medical records or billing records, etc.)
- How is data transferred from the EU to the U.S.? Is it transferred outside the U.S. again?

GDPR has special requirements for sharing information, especially across borders. This may require revising or entering into new agreements that contain the provisions required by GDPR.

- Identify your “legal basis” and implement “data minimization”; assess your data retention practices:

- Assess why you collect the personal data and what you use it for.
- Is there information you collect that is not really necessary for you and is just part of an old process no longer used?
- How long do you retain identified information?

GDPR requires you to have a purpose for collecting and using the information and also requires that you only collect the information that you need and that you only keep it for as long as necessary for the purpose for which it was collected. This may require looking at the data intake process and how you use the data, as well as your data retention practices.

- Create or amend your privacy disclosures. No, this is not the HIPAA Notice of Privacy Practices (“HIPAA Notice”).

continued on page 20

continued from page 19

- Other than your HIPAA notice, do you have notices that explain to the individuals, at or before the time personal data is collected, such things as what you are going to use the personal data for, with whom it will be shared, and how long you will keep it?

GDPR requires detailed disclosures. You may need to revise your online privacy notice, your patient notice and even the informed consent notice patients receive for clinical trials.

- Devise a process to respond, within 30 days, to access, deletion or correction requests by individuals:

- If a patient or customer asks for a copy of his or her records – would you be able to provide such copies, including any information held by your third-party providers about this person?
- If a customer asks that their record be deleted from your system, can you accommodate this request?

GDPR grants individuals the rights to access their information, have it amended, have it deleted, and/or object to marketing to them. These rights are not absolute, and there are exceptions to these rights, so it is helpful to scope out the exceptions and make sure that those responding to individual requests understand the exceptions. However, if the rights apply, you would need to respond within 30 days. Therefore, you would need to have a system to allow such responsiveness.

- Devise a process that allows notification of a data breach within 72 hours to Europe and assess how you handle notification if your databases include both U.S. and EU data together:

- Do you have systems in place to alert you of data breaches? Would you be able to get notifications to the relevant EU data protection authorities and/or the EU individuals within 72 hours?

GDPR requires that an unauthorized access or use of personal data (not just health data, not just identifiers, and even data that is encrypted in your system) would be notified to the relevant EU data protection authority within 72 hours unless the breach is unlikely to result in a risk to the rights and freedoms of individuals. Individuals would need to be notified if a data breach is likely to result in a high risk to their rights and freedoms. You would need to make sure that you are capable of doing this. If your systems store EU and U.S. individuals' personal data in one place, you would also need to assess and devise a plan for how to address any notification to the U.S. individuals.

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About the Author:

Odia Kagan is a Partner and the Chair of GDPR Compliance and International Privacy at Fox Rothschild LLP. She can be contacted at okagan@foxrothschild.com.

Revenue Integrity Forum Hosts Successful 2019 Charge Master Update

by Betsy Weiss, RN, MPH

The Revenue Integrity Forum hosted a successful educational event on December 12, 2018 at the New Jersey Hospital Association (NJHA). The Charge Master Update is an annual session addressing significant OPPS and MPFS reimbursement changes, coding changes and implications for the new year. This year the addition of a pricing transparency discussion was included. The sessions were presented by Vonda Moon, Principal, and Kristie Bailey, COC, Senior Manager of SunStone Consulting. The presentation was engaging, interactive and very relevant given the ongoing updates to the Medicare requirement of hospitals posting charges. The event was well-attended with 65 professionals representing hospitals, health systems and consulting firms.

Many thanks to VitalWare(tm) who sponsored the breakfast and to Heather Stanisci of Arcadia Recovery Bureau who provided snack baskets at the tables. Thanks also to Laura Hess and the NJ HFMA chapter, and to NJHA for their support.

The Revenue Integrity Forum will be hosting their next educational event on Tuesday, June 11, 2018, jointly with the CARE Forum, so stay tuned for more details.

About the Author:

Betsy Weiss is Chair of the NJ HFMA Revenue Integrity Committee and Director, Revenue Cycle at St. Francis Medical Center. She can be reached at bweiss@stfrancismedical.org.



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The Clinically Integrated Network: A Value-Driven Organization Structure

by Kyle Kobe



Kyle Kobe

The continued emphasis on improved cost, quality and population health has left many physicians and healthcare organizations scrambling to meet new industry demands. The Medicare Access and CHIP Reauthorization Act (MACRA) has changed how hospitals and physicians will be reimbursed, which is now largely based on their ability to reduce cost and improve the quality of patient care. With fee-for-service medicine still prevailing as the most common reimbursement model for healthcare organizations, drastic changes will need to be made to thrive in this environment.

One way hospitals and physicians are meeting these challenges is through the formation of clinically integrated networks (CINs). A clinically integrated network is the legal structure that facilitates authorized healthcare provider collaboration with the goal of jointly negotiated contracts and/or forming contracting networks that are high quality and low cost. A CIN is sometimes confused with clinical integration, which is defined as the coordination of patient care across conditions, providers, settings and time to achieve quality care that is safe, timely, effective and efficient. CINs are the vehicle and organizational structure that facilitates clinical integration by demonstrating value to the market. Building CINs will give the market value and offer payors, employers and consumers a new option. It will be critical for healthcare organizations to have capabilities to dive into their data and begin to understand how to provide value to their patients by offering more value-based care, in order to improve patient outcomes.

Five reasons why building a clinically integrated network is important:

1. Market Value: Create an end goal of a low-cost, high-quality unified healthcare network that will bring a new option for payors (Medicare, Medicaid, commercial payors and employers that have large populations contracting directly with the CIN) in the market to offer their patients.
2. Value/Risk Contracts: Enhance the ability to manage MACRA and other state and commercial alternative

payment models such as Bundled Payments, Shared Savings, Direct Contracting, etc.

3. Physician Independence: Physicians are given more independence. They no longer feel forced out of their markets or the need to be purchased by larger health systems. Forming a CIN allows them to reap the benefits of a large hospital organization without being purchased by one.
4. Coordination: Make it easier for hospitals, employed and independent physicians and other providers to work together to reach clinical and financial goals.
5. Population Health: Enable effective population health management and care coordination across the full care continuum.

Clinically integrated networks are on the rise and it will be important for healthcare financial professionals to acclimate themselves to this new model of care. Building a successful model is possible with the correct understanding of the fundamental elements. Not only are the following seven key elements important for success, but they are also required by the Federal Trade Commission (FTC) if forming a CIN.

Seven elements of success when building a clinically integrated network:

1. Legal Analysis & Options: Healthcare professionals should ensure that they are meeting the FTC requirements of their corporate structure.
2. Contract Modeling & Negotiation: Build with a value-based contract in mind. For example, a Medicare Shared Savings Accountable Care Organization (ACO) or self-insured employer contracts.
3. Quality & Performance Measures: With quality requirements in place, it is best to follow an existing program, instead of reinventing the wheel. MACRA, MIPs or any other existing quality programs are a great place to start.

continued on page 24

continued from page 23

4. Conditions of Participation: From the beginning it is important to define the way in which participating hospitals and physicians will engage with the CIN. Basically, this is a contract between the provider, as the host of the CIN, and the incoming participating partners. This will allow providers to maintain the high-quality standards of the CIN and allow them to scale participation.
5. Physician Governance & Leadership: The FTC requires physicians to play an active role in the leadership of the CIN. So as organizations are forming the CIN, they will need to identify strong physician leadership very early on. They will play an important role in defining quality standards, designing the flow of funds and advocating for other participating clinicians.
6. Incentive Alignment: The most common area of failure for a CIN is the inability to align compensation. It will be critical for the CIN to define and execute upon the flow of funds from the CIN all the way down to the physician.
7. Clinical and Financial Information Portal: Information sharing is also critical to the success of the CIN. It is

impossible to measure and improve cost and quality without accurate data and reporting capabilities. Successful CINs implement a standardized data warehouse where clinical and financial data are readily available to all participants.

The clinically integrated network needs to be built around an initial contract while keeping the end goal in mind. Begin with small steps by looking at the organization's strengths, working on small contracts with one clinic, providing quality care, and then expanding over time.

Clinically integrated networks are a game changer for healthcare organizations. Although it is different from how things have been done for several years in the market, it can benefit the organization overall by considering these elements for success.

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Brugalette v. Garcia – The New Jersey Supreme Court’s Most Recent Decision on the Patient Safety Act

by Paul E. Dwyer, Esq. and John Zen Jackson, Esq.



Paul E. Dwyer

I. INTRODUCTION

The New Jersey Supreme Court recently issued an important decision, *Brugalette v. Garcia*, relating to the Patient Safety Act N.J.S.A. 26:2H-12.23-25 (“PSA”)¹. A thorough understanding of the opinion is crucial for any hospital attorney, patient safety executive or medical malpractice practitioner. Although the opinion addresses many aspects of the PSA, the decision may be winnowed down to five central holdings.

- 1) When a claim of privilege is properly made and challenged, the trial court is required to perform an *in camera* review of the materials in question and issue specific rulings regarding the privilege.²
- 2) When a party claims that the privilege falls under the PSA, the trial court’s only inquiry is whether the hospital performed its self-critical analysis in compliance with the procedures found under the PSA and its associated regulations.³
- 3) Once the privilege is established, a trial court cannot order any version of the privileged document to be produced, even in a redacted form, nor can a trial court order that a Serious Preventable Adverse Event (“SPAЕ”) be reported to the Department of Health.⁴
- 4) If the privileged information is available from a source other than those enumerated in the statute, it is subject to discovery from that source.⁵
- 5) When pertinent, discoverable information is located in voluminous documents, the trial court may order the producing party to create a narrative for the requesting party, specifying where particular information can be found, though such an order should not be issued routinely.⁶

Each of these holdings is discussed below:

II. PATIENT HEALTH AND SAFETY MOVES TO THE FOREFRONT OF PUBLIC CONCERN

In 2000, the Institute of Medicine (“IOM”) published its landmark study *To Err is Human*.⁷ Extrapolating from prior in-

dependent studies, the IOM concluded that between 44,000 and 98,000 hospital patients die annually from preventable adverse events.⁸

Spurred by these alarming figures, Congress passed the Patient Safety and Quality Improvement Act in 2005.⁹ New Jersey had passed its own Patient Safety Act a year earlier.¹⁰ Both statutes sought to reduce these tragic incidents by creating a privileged non-punitive learning environment that would encourage healthcare providers to engage in self-critical analysis believed to be the key to improving patient safety and the quality of healthcare.¹¹



John Zen Jackson

III. CASE FACTS AND PROCEDURAL HISTORY

Although numerous state courts and several federal courts have decided cases under the federal act,¹² the New Jersey Supreme Court addressed the parameters of this state’s act for only the second time earlier this year.

In *Brugalette v. Garcia*,¹³ plaintiff presented to defendant Chilton Memorial Hospital’s emergency room (hereinafter, “the Hospital”) complaining of a week’s fever with abdominal and body pains. She was diagnosed with pneumonia and admitted to the hospital. Further examination revealed a pelvic abscess due to a ruptured appendix. Her physician then determined that the plaintiff was developing necrotizing fasciitis in her thigh muscles and right buttock due to the abscess draining around a nerve, necessitating multiple surgeries. Plaintiff’s fever dissipated and her abdominal pain subsided, but her leg pain worsened. Upon discharge three weeks after her admission, plaintiff reported having residual pain and injuries to her legs and buttocks, later claiming that they were permanent.

Two years after her admission, plaintiff brought a medical malpractice action against the Hospital and her treating physicians.

During the course of discovery, plaintiff served interrogatories upon the Hospital requesting copies of any statements regarding the lawsuit and the circumstances surrounding their creation. In response, the Hospital disclosed in a privilege log that it possessed two reports regarding the incident and claimed that the reports were privileged under the New Jersey Patient Safety Act.¹⁴

Plaintiff moved to compel the production of the privileged documents. The Hospital cross-moved for a protective order, providing the certification of a physician administrator that the two incident reports were prepared “for the sole purpose of complying with the requirements of the PSA” and that the reports were provided to the Patient Safety Committee but no other committee.¹⁵

After argument and an *in camera* review, the trial court ordered the production of a redacted version of one of the incident reports, marked DCP-2.¹⁶ The trial court went on to hold that the plaintiff had suffered an SPAE, as that term is defined under the PSA, which it had failed to report to the Department of Health as mandated by the statute.¹⁷ Therefore, the Hospital was ordered to report. Further, the trial court held that where a healthcare provider fails to report an SPAE in an “arbitrary and capricious” manner, it loses its privileges under the PSA.¹⁸ The court ruled that the Hospital had not acted arbitrarily and capriciously, so it did not forfeit its privileges.¹⁹ The court redacted from DCP-2 those portions providing a self-critical analysis, but ordered the factual portion disclosed. The trial court stayed its own order so that the parties could exercise their appellate rights.

The Appellate Division reversed,²⁰ holding that the only precondition to preserve the privilege was that the Hospital perform its self-critical analysis in conformance with the PSA and its associated regulations.²¹ The Appellate Division also ruled that the trial court had erred in finding that an SPAE had occurred because its determination was unsupported by expert opinion.²²

The Supreme Court took up the appeal.

IV. THE NEW JERSEY SUPREME COURT’S DECISION

A. GENERAL PRINCIPLES OF THE PSA

The New Jersey Supreme Court noted that the Legislature sought to reduce adverse events “by fostering a non-punitive, confidential environment in which healthcare facilities can review internal practices and policies and report problems without fear of recrimination while simultaneously being held accountable.”²³ The PSA requires healthcare facilities to create patient safety committees of qualified professionals to perform self-critical analyses, create evidence-based plans to increase patient safety, and to provide continual training to hospital personnel

regarding patient safety. The Court held that once the committee is made aware of an SPAE, it is required to (i) perform a root cause analysis to identify the causes of the adverse event and take corrective action, and (ii) report the event to the Department of Health and the patient.²⁴ Failure to report can subject the healthcare facility to administrative monetary penalties.²⁵

The statute makes the report to the Department of Health and “[a]ny documents, materials, or information developed by a healthcare facility as part of the process of self-critical analysis” privileged.²⁶ The Court held that the privilege envelopes the healthcare facility’s entire self-critical analysis process, including deliberations and decisions.²⁷ The privilege precludes admission of the material into evidence in any civil, criminal, or administrative action.²⁸ The privilege attaches, however, only to documents, materials or information created “exclusively during the process of self-critical analysis.”²⁹ Such material may, however, be discoverable if obtained in “any … context other than those specified” under the statute.³⁰

The sole condition to the application of the statute’s privileges is that the healthcare facility conducted its self-critical analysis in conformance with the procedures delineated in the PSA and its associated regulations.³¹

B. PROCEDURES TO BE FOLLOWED BY THE TRIAL COURT WHEN A PRIVILEGE IS CLAIMED AND CHALLENGED UNDER THE PSA

The Supreme Court then turned to the ruling of the trial court. The Court held that where a party claims privilege and describes the general nature of the privileged information, such as appears in a privilege log, and its adversary challenges the assertions, it is incumbent upon the trial court to conduct an *in camera* review of the material and “make specific rulings as to the applicability” of the privilege.³²

The Court further held that the trial court erred in even considering whether the Hospital correctly determined that an SPAE had occurred. “The Legislature inserted no role for a trial court to play in reviewing the SPAE determination made by a patient safety committee of a healthcare facility.”³³ Further, the trial court erred in requiring production of the redacted incident report and ordering the Hospital to report the event to the Department of Health.³⁴ The PSA vests oversight of the patient safety process in the Department of Health and enforcement powers with the Commissioner of Health.³⁵

The Court, in turn, vacated the trial court and Appellate Division’s opinions as they related to the standard to be applied in determining whether an SPAE had occurred.³⁶

Ultimately, the Court held that a trial court cannot order the discovery of a document created during the self-critical analysis process, even in a redacted form.³⁷ Nor can a trial court consider the healthcare facility’s determination of whether an

continued on page 28

continued from page 27

SPAЕ occurred.³⁸ The trial court is prohibited from ordering the disclosure of an event to the Department of Health.³⁹

C. THE PRODUCING PARTY MAY BE ORDERED TO CREATE A NARRATIVE SPECIFYING WHERE INFORMATION CAN BE FOUND IN VOLUMINOUS DOCUMENTS WHEN EQUITY DICTATES

The Court went on to hold that the Patient Safety Act privilege does not protect information otherwise discoverable. Within the “thousands of pages” of medical records disclosed by the Hospital to the plaintiff, “there are notations … that, when read together, reveal the nature of the events underlying the divergent Serious Preventable Adverse Event determinations of the committee and the trial court.”⁴⁰ The pertinent information was found in nine of approximately 4,500 pages of medical records produced.⁴¹

Although such a solution should not be “routinely” ordered, the Court held that under these circumstances, where the pertinent information is scattered in a few pages of voluminous records produced, the Hospital should be ordered to provide a “narrative” that “specifies for the requesting party where responsive information can be found.”⁴² Where a party, more familiar with its records and recordkeeping practices than its adversary, produces a mass of documents within which discrete information is located necessary to respond fully to a discovery request, a balancing of the equities mandates that the producing party provide a narrative directing the requesting party to the places within the record where the pertinent information is located.

V. CONCLUSION

Privileges are narrowly construed. The battle over privilege under the Patient Safety Act is won or lost when the patient safety plan is completed and the Patient Safety Committee is established and functioning. The Court was quite clear that the only way to establish and maintain the privilege is to adhere to the strictures of the statute and corresponding regulations.

The party asserting the privilege is obligated to prove all its elements. Any medical malpractice defense attorney must be prepared to muster the evidence necessary to maintain the privilege.

In the case of the Patient Safety Act, however, the privilege is established when the appropriate material is developed in accordance with procedures set forth in the statute. And then no court or other administrative body can order its disclosure.

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Footnotes

¹234 N.J. 225 (2018).

²*Id.* at 235.

³*Id.* at 247.

⁴*Id.* at 249.

⁵*Id.* at 246-247.

⁶*Id.* at 256.

⁷L. Kohn, J. Corrigan, M. Donaldson, ed., *To Err Is Human: Building A Safer Health System*, Institute of Medicine, National Academy Press (2000).

⁸*Id.* at 31.

⁹42 U.S.C. § 299-b (21) *et seq.*

¹⁰N.J.A. 26:2H-12.23 – .25.

¹¹73 Fed. Reg. 70732 (November 23, 2008); N.J.A. 26:2H-12.24 e. and f.

¹²Charles v. Southern Baptist Hospital of Florida, 209 So.3d 1199 (Fla. 2017); Baptist Hospital Richmond, Inc. v. Clouse, 497 S.W.3d 759 (Ky. 2016); Daley v. Teruel, 2018 Ill. App. (1st) 170891 (Ill. App. 1st Dist. 2018); University of Kentucky v. Bunnell, 532 S.W.3d 658 (Ky. App. Ct. 2017); Dunn v. Dunn, 163 F.Supp. 3d 1196 (M.D. Ala. 2016); Department of Financial and Professional Regulation v. Walgreen Company, 970 N.E.2d 552 (Ill. App. 2nd Dist. 2012).

¹³234 N.J. 225 (2018).

¹⁴*Id.* at 233-234. The hospital claimed a litany of privileges including those under Peer Review and Improvement Act 42 U.S.C. § 11101 *et seq.*; the Patient Safety Act, N.J.A. 2A:84A-22.8; the healthcare Quality Improvement Act, 42 U.S.C. § 11101 *et seq.*; the common law self-critical analysis privilege, and Hospital policy. Ultimately, only the privilege under the New Jersey Act was pursued.

¹⁵In order to be privileged under the PSA, an incident report must have been completed for the purpose of providing it to a statutorily-created Patient Safety Committee in accordance with a patient safety plan. N.J.A. 26:2H-12.25.b.; N.J.A.C. 8:43E-10.4 (a)-(b) and 10.9(b)1.

¹⁶Brugaletta, 234 N.J. at 234.

¹⁷*Id.* at 235.

¹⁸*Id.*

¹⁹*Id.*

²⁰Brugaletta v. Garcia, 448 N.J.Super. 404, 408, 419 (App. Div. 2017).

²¹*Id.* at 414-415.

²²*Id.* at 418-419.

²³Brugaletta, 234 N.J. at 241.

²⁴*Id.* at 242.

²⁵*Id.*, citing N.J.A.C. 8:43E-3.4(a)(14).

²⁶*Id.*

²⁷*Id.* at 247.

²⁸N.J.A. 26:2H-12.25g.(1).

²⁹Brugaletta, 234 N.J. at 243 (internal citations omitted).

³⁰N.J.A. 26:2H-12.25h.

³¹Brugaletta, 234 N.J. at 247.

³²*Id.* at 245.

³³*Id.* at 245-246.

³⁴*Id.* at 249.

³⁵*Id.* at 246, citing N.J.A. 26:2H-12.25j.

³⁶*Id.* at 246-247.

³⁷*Id.*

³⁸*Id.* at 246.

³⁹*Id.* at 249.

⁴⁰*Id.* at 250.

⁴¹*Id.* at 256-257.

⁴²*Id.* at 256.

New Jersey's Exchange Enrollment Down, But That's Not The Whole Picture

by Theresa Edelstein and Colleen Picklo

As of the end of the official 2019 open enrollment period, Dec. 15, New Jersey has lost 18,108 individuals from the federally facilitated exchange. This is according to the Centers for Medicare and Medicaid Services' (CMS) week 7 enrollment snapshot versus CMS' snapshot for the comparable timeframe last year. This represents a decrease of approximately 7%. However, New Jersey was a national leader in developing market stabilization precautions during 2018. Because of this, Exchange enrollment is only part of the equation. New state level efforts may lead to a significant change in the number of individuals purchasing insurance directly from carriers.

New Jersey Mitigation

Over the last two years, the Patient Protection and Affordable Care Act (ACA) has undergone changes to its requirements that many stakeholders cautioned could negatively impact enrollment. These changes included decreased outreach funding, allowing for the sale of plans such as short-term limited duration and association health plans that don't meet all of the standard of ACA compliant plans (New Jersey restricts the sale of these types of plans) and the decision to stop paying cost-sharing reductions.

Perhaps the most impactful of the changes concerns the individual mandate. Beginning in 2019, the federal individual mandate penalty required under the ACA will decrease to \$0, effectively removing the penalty. A number of reports have indicated that this change will negatively impact health insurance markets by removing an incentive for healthier people to purchase insurance, which will lead to excessive premium increases.

In New Jersey, efforts were made to mitigate the impact of these federal level changes and for the first time 2019 open enrollment had the full support of state government. The Departments of Banking and Insurance, Human Services, and Health all engaged in coordinated efforts to promote open enrollment. State officials helped educate navigators, made themselves available for open enrollment events, engaged media in outreach efforts and provided outreach funding.

The state also implemented legislative responses to the federal change including enactment of a law that requires all New

Jersey residents to have health coverage or pay a penalty, effectively negating the elimination of the federal mandate.

If New Jersey residents do not purchase health insurance for 2019, they will be assessed a penalty when filing taxes in 2020, similar to what was previously required under federal law. In fact, the mandate mirrors the former federal penalty requirements by assessing an annual penalty of 2.5% of a household's income or a per-person charge — whichever is higher. The maximum penalty based on household income will be the average yearly premium of a bronze plan. If it's based on a per-person charge, the maximum household penalty will be \$2,085. Hardship exceptions for individuals who cannot afford coverage will continue to be available under the state law.

Additionally, New Jersey passed legislation that required the creation of a reinsurance plan to reimburse carriers for certain high-cost claims in the individual health insurance market. The reinsurance plan uses a mix of federal and state funds, which led to individual health insurance premiums that are approximately 15% lower than they would be without the plan.

Finally, perhaps one of the most impactful decisions the state made was to allow insurers to silver-load only plans offered through the Exchange. Silver-loading is a process that was first permitted during 2018 that allowed health insurers to load a surcharge onto silver plans both on and off the Exchange to make up for the loss of cost-sharing reduction payments. The state's decision not to permit silver-loading plans

sold directly by carriers led to significantly lower premiums for those plans. In fact, the least expensive silver level plans available for purchase are off the Exchange.



Theresa Edelstein



Colleen Picklo

If New Jersey residents do not purchase health insurance for 2019, they will be assessed a penalty when filing taxes in 2020, similar to what was previously required under federal law.

Exchange Enrollment Trends

According to CMS data, New Jersey already experienced the first loss of individuals from the Exchange during the 2018 open enrollment period. At the end of the 2018 open enrollment period, data indicated that 20,285 fewer individuals made plan selections than had during the 2017 open enrollment period.

Prior to 2018, data indicated year-over-year increases in Exchange plan selection enrollment. Since the first open enrollment period during which 161,775 individuals made plan selections for 2014 to the 295,067 individuals that made plan selections for 2017, the Exchange had an increase of 133,292 individuals. Compare that to the decrease in individuals making plan selections between 2014 and 2019 plan selections totaling 94,899 individuals, and it is evident something is causing individuals to move off of the Exchange.

There are a number of reasons why individuals can move on and off the Exchange, a process referred to as "churn." Individuals can move to Medicaid, gain employer-based coverage, purchase coverage directly from carriers, move out of state or drop coverage. However, these factors were all considerations during the prior open enrollment periods when enrollment trended upward.

A review of federally released premium and demographic data provides some details on enrollment that can offer further insight for consideration concerning "churn."

Federal data on the cost of post-subsidy premiums for the average silver plan over the years indicates that, even though 2015 and 2016 were identified as the years with the most expensive premiums post-subsidy, \$172 and \$161 per month,

those years both experienced net increases in Exchange plan selection enrollment of 92,541 and 34,257 individuals, respectively. Post-subsidy premiums for eligible individuals are \$157 per month; therefore, individuals who were purchasing at the higher subsidized costs arguably would continue to do so now.

Additionally, data concerning the individuals who are eligible for subsidies have consistently indicated that approximately 83% of individuals are eligible for subsidies. In comparing that to the 7% decrease in Exchange plan selections, it is evident that a larger percentage of individuals, the 17% that don't receive subsidies, might have potentially all been motivated to move off the Exchange, but clearly did not.

It was anticipated that the changes at the federal level would impact marketplace enrollment. But state efforts to stabilize the state's individual insurance market to stave off massive premium hikes exhibited an impact. Until state-level data is available, the final impact is unknown, but there are strong indicators that New Jersey's efforts led to some success. Now, the state must continue to investigate additional efforts that could continue to strengthen the market including efforts to address affordability for all.

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•Focus on Finance•

Lease Accounting Checklist for Healthcare Organizations

By Maria A. Inciardi, MS, CPA

Q. What updates to the leasing standards were made by the Financial Account Standards Board (“FASB”) for healthcare organizations and when do these standards become effective?

A. The new year will bring in effect the new Financial Accounting Standards Board (“FASB”) update to the leasing standards for many healthcare organizations. For public companies, the new leasing standard takes effect in just a matter of days for fiscal years beginning after December 15, 2018. For private companies, that date is December 15, 2019 (for fiscal years beginning after that date) or December 15, 2020 (for interim periods within fiscal years beginning after that date).

To summarize the accounting changes, basically, if your lease agreements have terms greater than 12 months, the present value of all fixed lease payments are to be recorded as right-of-use (“ROU”) assets and liabilities on the books. There are also a host of additional disclosures necessary to document management assumptions in calculating lease payments. Lessees will still have two options for categorizing their leases. The first option is financing leases, which are essentially the same as capital leases, and the second is operating leases, which will be recorded on the balance sheet for the first time.

The lease accounting changes will affect nearly every industry; however, the impact will depend on each individual company’s use of leases. As an example, in the healthcare industry hospital systems and large multi-physician practices that have several locations through real estate leases will see a substantial impact from the implementation of these standards.

As the new year approaches, here are a few things to consider in making sure your organization is in compliance with these upcoming standards:

1. Study the new regulations

Researching and understanding ASU No. 2016-02, *Leases (Topic 842)* is a great starting point. Since the introduction of the new leasing standard, the FASB has issued sev-

eral updates to ease the burden of implementation. They include some clarifying language on some perceived inconsistencies and the ability to elect a “year of adoption” implementation, rather than an “earliest period presented” model.

2. Create a transition team
Assign a group of colleagues and staff with the suitable skills necessary to understand the new standards and to spearhead the implementation efforts to reduce the risk of non-compliance.
3. Develop an implementation timeline
A transition team should consider developing a timeline for compliance efforts.
4. Inventory your leases
Probably the greatest undertaking in complying with the new leasing standards will be compiling your lease portfolio and extracting the relevant detail from each agreement to ensure that you have the necessary information for reporting purposes.
5. Assess your technological capabilities
Determine if your organization has the technological capabilities to maintain and report the data necessary to comply with the new accounting standards.
6. Select the right technology
There are several options available in the marketplace that can greatly assist in the preparation, transition and implementation phases of the new FASB leasing standards. From tracking lease renewals, date monitoring, and document management, to calculating the monthly lease liability and ROU asset, the right technology suitable for your organization will ensure that you have the information you need to account for the new FASB standards.
7. Evaluate other implications of implementation of the new standard



Maria A. Inciardi

continued from page 31

- Considerations should be made to determine the implications of the new lease standards on key performance metrics, debt covenants, taxes, and internal operations. Key performance metrics that are expected to be affected by these changes are the leverage ratio (debt/equity), current ratio (current assets/current liabilities) and debt to earnings before income taxes, depreciation, and amortization ("EBITDA"). These effects could also lead to lease negotiations or re-negotiations as these standards could affect the organization operationally.
8. Communicate with those charged with governance
Ensure that governing bodies of the organization are

up-to-speed with the overall impact of these standards on the organization, as well as the ongoing implementation efforts.

This is a great starting point for ensuring that your organization starts the new year on your journey to complying with the new lease accounting standards.

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•Focus on...New Jobs in New Jersey•

JOB BANK SUMMARY LISTING

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

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

Job Position and Organization

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CentraState Medical Center

Budget Analyst III
Hackensack University Medical Center

Compliance Auditor Full Time
St. Joseph's Healthcare System

Manager, Finance Faculty Practice
The University of Vermont Medical Center

Manager of Revenue Integrity
The University of Vermont Medical Center

Corporate Director Materials Management
CentraState Medical Center

Senior Financial Analyst
Virtua

Financial Analyst II - Managed Care
AtlantiCare

Senior Reimbursement Analyst
University of Vermont Medical Center

Executive Director Financial Operations
St. Joseph's Healthcare System

Reimbursement Budget Analyst
University Hospital Newark, NJ

Physician Contract Officer Full Time * Paterson, NJ
St. Joseph's Healthcare System

Accounts Receivable Supervisor
MediCentrix

Director Patient Financial Services
Bancroft

Chief Financial Officer
ID Care, P.A.

Manager Budget & Reimbursement
CentraState Medical Center

Perspectives on Healthcare

2019 New Year's Resolutions for CFOs

by Lew Bivona, CPA, AFE



Lew Bivona

Where will the ACA go? Will it get repealed? Will it get replaced? Based upon the House changes, it looks like the ACA still is an uphill (pun intended) battle. Maybe President Trump taking on the drug industry could provide needed relief for hospital costs, but remember, the Democrats allowed this overpayment to happen when Part D was added so don't hold your breath on that either. Despite short-term successes in enrollment, many states have little-to-no competition and significant healthcare inflation. Personal and family deductibles often have eclipsed the ability to pay for them.

How do you protect your organization and plan to thrive for 2019 and beyond? Here are eight trends that will continue to occur in 2019. Acting on them strategically can help get your ship in order and lead to a more prosperous new year.

1. Hospital systems will continue to acquire physician and specialty practice groups to manage larger populations and strengthen their brand. Remember, except for a handful of insurers across the country, hospitals and their physicians are required to provide servicing to their products and services; use this to your negotiating advantage.
2. Hospitals are notorious for not following up on disputed invoices. Rejections are your problem; reply timely to queries or requests for information! If you do not, your ability to collect interest on past due amounts is compromised.
3. Not all edits performed by insurance companies comply with CCI guidelines; your HIM Departments should be cognizant of this fact. Also, make sure that if CCI edits apply that your hospital is using the appropriate modifiers when dropping invoices.
4. As healthcare reform continues to be contemplated on the reimbursement side, you can count on hospitals getting the short end of the stick. The AMA seems to have better lobbying efforts than the AHA. Push to make your voice heard by responding to data calls and being involved as an organization!
5. Evaluate your service areas for competitive disadvantages. As a hospital, you cannot, for example, expect to do colonoscopies for \$2,000 per service when the free standing surgi-center is performing them at \$800 a clip! Productivity and cost sensitivity are key concerns for hospital executives as employers are narrowing their networks to effectuate and sustain competitive pricing for their own businesses.
6. New technologies can help increase patient satisfaction and decrease outcome variabilities, but should also be viewed from a cost/benefit perspective. Not every hospital in the system will need a new piece of Equipment X; perhaps a centrally located device is your best option.
7. Be prepared to see an increase in uncompensated care. Without the ACA mandate, premium subsidies and tax penalties, more people are expecting to drop insurance.
8. Better align your hospital and physicians with their own future. Payment models enacted by health plans have seen improved quality and cost outcomes due to value-based arrangements and they will continue to push for them in your contracts.

Happy 2019! I can virtually guarantee that if you apply this advice, you will be here to read my 2020 new year's advice!

About the author

Lewis D. Bivona Jr., CPA, AFE currently functions as a Market Regulation Examiner and a Financial Condition Examiner for The INS Companies. Lew can be reached at LewCPA@gmail.com.

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