Diving Deep into ICD-10
See page 5
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“Still Time” to Get Ready for ICD-10, and CMS Offers Help for the Transition
by Laurie Johnson, MS, RHIA, CPC-H, FAHIMA ................................................................. 5

Telemedicine and Beyond: The Current Status of the Law and Its Future
by Cacilia K. Hahn .................................................................................................................. 8

What’s In Your Beach Bag?
NJ HFMA Members Share Their Favorite Reads ........................................................................ 12

Accountable Care Organizations – The Jersey Generations
by Neil M. Sullivan, Esq. ......................................................................................................... 15

SCOTUS Once Again Saves the Affordable Care Act
by James A. Robertson, John W. Kaveney and Cecilia K. Hahn ........................................... 19

High Deductible Health Plans: Increasing in Popularity with Consumers and What That Means for Hospitals
by Kevin Oakley .................................................................................................................... 24

Poolside Physical Therapy Helps Young Swimmers Prevent Injuries
by Jeff Erickson ...................................................................................................................... 26

Equipment Financing and Bond Financing How Healthcare Organizations are Making the Best Use of Each Financial Product
by Jennifer Vanegas ............................................................................................................... 31

2014 Annual Institute Photo Recap ...................................................................................... 34-35

2015 Institute Schedule at a Glance ..................................................................................... 36-37
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<th>Issue Date</th>
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Hello everyone,

As the President of the New Jersey HFMA Chapter for the 2015-2016 Chapter year, I wanted to welcome everyone to the Summer Edition of the Garden State Focus. I am very excited to help lead our Chapter forward over the next year. The New Jersey HFMA Chapter has always focused on providing educational content, collaborative forums, and networking events to its members to assist them in this ever changing environment. This year’s national theme is Go Beyond. Building success in a changing healthcare economy will require going beyond the status quo and finding new ways to lead the healthcare industry and healthcare organizations forward in this period of transition. Success in the future will require healthcare entities to go beyond the hospital centric models with new forms of cooperation and collaboration throughout the continuum of care. The New Jersey Chapter is ready to evolve with the changes and go beyond the norm, and the board and committee chairs and co-chairs are hard at work planning the education and networking events for the upcoming Chapter year. I will highlight their efforts in each issue of the Focus.

For those new to the Chapter or anyone interested in learning more about a specific aspect of the complicated healthcare industry, our Chapter has a tremendous structure of discussion forums and committees that provide the opportunity for small group discussions, peer interactions, and networking. Each issue of our Focus publication includes contact information for these forums and committees on the “Who’s Who in NJ Chapter Committees” page. I encourage you to flip to the “Who’s Who in NJ Chapter Committees” page, pick a forum that may interest you and dial-in or just show up at their next monthly meeting. There is no cost to participate, no advance sign-up or registration required, and the opportunity to learn and network is immediate – two critical things in this time of change within our industry.

On June 9, 2015, the Revenue Integrity Forum hosted Bright Lights, High Performance Healthcare education session in Woodbridge. This was a great event and had a networking cocktail hour that followed. We have heard from the membership in the last survey that we should host more networking events, and we heard you. The energized Membership and Networking committee is planning several networking events throughout the year. The first was held in July at the Watermark in Asbury Park, “It’s a Shore Thing! Summer Networking Kickoff,” and reviews were good.

Information for registering for any of our education sessions or the Annual Institute down at the Borgata in Atlantic City (October 7, 2015 through October 9, 2015) can be found on the website, along with other information on events and information for the Chapter.

I am very grateful for all of the support of the New Jersey HFMA membership and especially for the efforts of those who volunteer, including the Officers, Board of Directors, Committee/Forum Chairs and Co-Chairs, and all those who participate in the many committees and forums. I know there’s a significant time commitment and we couldn’t do it without everyone’s help! But I want to especially thank Tracy Davison-DiCanto, our outgoing Chapter President, who has been dedicated to the New Jersey Chapter which under her leadership was honored at National ANI receiving several Education and Yerger Awards. Pictures are up on our Facebook page. I would also like to recognize the outgoing Board and Advisory Committee members- Mary Taylor, Roe Nuzzo, Steve Bilsky, and Stella Visaggio. Your hard work and commitment has not only been appreciated and developed the future leaders of the Chapter, but has helped this Chapter grow.

I am committed to continuing the nationally recognized educational programing to our members, and we are working on additional networking events for the upcoming year. So please stay connected through our weekly Pulse newsletters, the Focus, monthly discussion forums and other events.

I hope that you enjoy this edition of the Focus and I look forward to meeting and interacting with more of you over this upcoming year. If you have any questions or idea, please do not hesitate to reach out to me and the rest of the New Jersey HFMA leadership.

Heather Weber
Unlike a fine wine...

Denials do not improve with age.

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“Still Time” to Get Ready for ICD-10, and CMS Offers Help for the Transition

by Laurie Johnson, MS, RHIA, CPC-H, FAHIMA

Although there are less than three months left until the implementation of the ICD-10 systems, the Centers for Medicare & Medicaid Services (CMS) are still sending optimistic messages, such as, “ICD-10 is rapidly approaching, but there is still time to get ready.”

For the physician-specific message, it adds a little more sobriety by warning them that “the ICD-10 transition will affect every part of your practice, from software upgrades, to patient registration and referrals, to clinical documentation and billing. With the compliance date quickly approaching, now is the time to get ready.”

The latest positive message issued to get procrastinators moving came in a July 6 news release entitled “CMS and AMA Announce Efforts to Help Providers Get Ready for ICD-10.” Working together, CMS and AMA say that they will educate providers through webinars, on-site training, educational articles and national provider calls—plenty of which has already been done. The end goal is to help all healthcare providers learn about the updated codes and prepare for the transition.

In addition to urging providers to be proactive, CMS has developed a few safety nets that it will put in place on October 1, including those below.

Focus on Flexibility

To mitigate potential problems, and in response to requests from the provider community, CMS released guidance that will “allow for flexibility in the claims auditing and quality reporting process as the medical community gains experience using the new ICD-10 code set.” (The guidance document can be downloaded at https://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD-10-guidance.pdf.)

A valid ICD-10 code still will be required on all claims starting on October 1, 2015, but some lenience will be allowed. For 12 months after ICD-10 implementation, explains CMS, Medicare review contractors “will not deny physician or other practitioner claims billed under the Part B physician fee schedule through either automated medical review or complex medical record review based solely on the specific of the ICD-10 diagnosis code as long as the physician or practitioner used a valid code from the right family.”

A claim, however, still could be chosen for review for reasons other than the specificity of the ICD-10 code.

Monitoring Implementation

CMS says it will establish a communication and collaboration center for monitoring ICD-10 implementation, explaining that the center will quickly identify and initiate resolution of issues that arise as a result of the transition.

As part of the center, and at the AMA’s request, CMS will hire an ICD-10 ombudsman to help receive and triage physician and provider issues. He or she will work closely with CMS’s regional office representatives to address concerns. More guidance will be forthcoming from CMS on this process.

Plethora of Online Education

The CMS website lists resources that can jump-start provider efforts, particularly physicians who are lagging behind. For example, there is the ICD-10 Quick Start Guide, which includes the five steps that have absorbed proactive healthcare industry leaders for months. Each step highlights “crucial activities” such as the following:

• Make a plan.
• Train your staff.
• Update your processes.
• Talk to your vendors and health plans.
• Test your systems and processes.

In addition to various administrative tools, CMS offers an ICD-10-CM Web-Based Training Course and several ICD-10 videos, including:

• Introduction to ICD-10 Coding
• ICD-10 Coding and Diabetes
• Estimating the Impact of the Transition to ICD-10 on Medicare Inpatient Hospital Payments

continued on page 6
Watch for Billing Guidance

When ICD-10-CM becomes a reality on October 1, 2015, healthcare providers and coding professionals will need to be aware of all of the guidelines that CMS has issued, including the latest in MLN Matters SE1408. This guidance updates information on billing for dates that span the ICD-10 implementation date. (For SE1408, go to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1408.pdf.)

It addresses the most common billing question: Would you assign an ICD-9 code or an ICD-10 code if a Medicare beneficiary is admitted as an inpatient in late September, 2015 and is discharged after October 1, 2015? CMS includes a table in the memo that includes the following information:

<table>
<thead>
<tr>
<th>Bill Types</th>
<th>Facility Type/ Services</th>
<th>Claims Processing Requirement</th>
<th>Use From or Through Date?</th>
</tr>
</thead>
<tbody>
<tr>
<td>11X</td>
<td>Inpatient hospitals (including prospective payment system, critical access, long-term care, and others)</td>
<td>If the hospital claim has a discharge and/or through date on or after 10/1/15, then the entire claim is billed using ICD-10.</td>
<td>Through</td>
</tr>
<tr>
<td>12X</td>
<td>Inpatient Part B hospital services</td>
<td>Providers must split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>From</td>
</tr>
<tr>
<td>13X</td>
<td>Outpatient hospital</td>
<td>Same as the above for TOB 12X</td>
<td>From</td>
</tr>
<tr>
<td>14X</td>
<td>Non-patient laboratory services</td>
<td>Same as the above for TOB 12X and 13X</td>
<td>From</td>
</tr>
</tbody>
</table>

CMS also provided the following guideline for the three-day and one-day outpatient payment windows:

All outpatient services (with a few exceptions) are required to be bundled on the inpatient bill if rendered within three days of an inpatient stay. If the inpatient hospital discharge is on or after 10/1/2015, the claim must be billed with ICD-10 for those bundled outpatient services.

The Ultimate Motivator

Here’s the bottom line for any providers who are still in denial about ICD-10 implementation: The Medicare claims processing systems will not have the capability to accept ICD-9 codes for dates of services after September 30, 2015, nor will they be able to accept claims for both ICD-9 and ICD-10 codes.

About the Author

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Doctors often wonder whether it would be possible to remotely assess, diagnose and treat patients through the use of telemedicine technologies. This might be beneficial for many reasons. For example, healthcare may be available to a broader group of patients. It will allow patients greater choice in the types of specialists they would like to consult. For those patients that cannot travel, it will also give them access to medicine they would not otherwise have.

Telemedicine is a developing area of the law without many well-established precedential cases readily available. Moreover, because of the localized nature of the regulation of the practice of medicine, state laws must be analyzed by anyone considering practice in another state to properly determine the risks associated with cross-border treatment of patients. There are, however, several general principles that appear to hold true, from which conclusions may be extrapolated.

Preliminarily, a physician must be licensed in the state in which the patient is located (because the treatment of that patient would constitute the practice of medicine). In addition, the physician typically must perform a physical examination of the patient before prescribing and/or dispensing any medications. Another consideration is the prescription of medication. Some states have stringent restrictions on internet prescribing and strict requirements regarding histories and physical examinations prior to the prescribing or dispensing of prescription drugs.

Governing Law. This cross-border practice of medicine creates the additional complication requiring a legal determination as to which state's laws or whether both states’ laws would govern a doctor’s activity. Logically, it is safe to assume that, at a minimum, the laws of the state in which the patient resides would govern the activity because the patient’s state of residence has a legitimate and long respected public policy interest in protecting its residents. It is less clear, however, whether the law of the state in which the doctor is located would also govern.

Telemedicine Model. The American Telemedicine Association (“ATA”) identifies itself as the principal organization bringing together telemedicine practitioners, healthcare institutions, vendors and others involved in this field. In accordance with its mission, the ATA has attempted to identify requirements and guidelines for the implementation and promotion of telemedicine. The ATA specifically identifies state-by-state medical licensure requirements and practice restrictions, such as the requirement of a physical examination. These are the two greatest long-standing barriers to the implementation and growth of telemedicine.

Included in the ATAs suggested core standards for telemedicine is the requirement that doctors be fully licensed not only in their respective state, but also in the state where the patient is located. Doctors are warned to also follow all laws and regulations in both his/her home state and the state where the patient is located. This admonition is, in part, grounded in the historical approach of holding doctors to the standard of care practiced by members of the same practice specialties in the local geographic location. This puts significant time and expense burdens on a doctor to obtain and maintain a license in every state where his/her patients are located.

On April 26, 2014, the Federation of State Medical Boards adopted a “Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine” (the “Model Policy”). Though state medical boards are not required to adopt the Model Policy, boards may use it as a guide. The Model Policy recognizes that telemedicine technologies facilitate communications with doctors and their patients or other health care providers, including prescribing medication, obtaining laboratory results, monitoring chronic conditions, providing health care information, and clarifying medical advice. Emphasized is the balance between enabling access to care and ensuring patient safety. Importantly, the Model Policy supports a consistent standard of care and scope of practice notwithstanding the delivery tool or business method in enabling doctor-to-patient communications. Treatment, including prescribing medication, based solely on the review of an online questionnaire does not constitute an acceptable standard of care. Doctors that choose to use telemedicine tech-
nologies are encouraged to take appropriate steps to establish a patient-physician relationship and conduct all appropriate evaluations and patient history consistent with traditional standards of care for a particular presentation.

The Model Policy provides that videoconferencing and “store and forward” technology may be a part of telemedicine practice but provides that, generally, audio-only, email, and instant messaging technologies are not telemedicine. The doctor providing services must be licensed by, or under the jurisdiction of, the medical board where the patient is located. The practice of medicine occurs where the patient is located at the time telemedicine technologies are used. The doctor must obtain informed consent for telemedicine consultation which should be filed with the patient’s medical record. An emergency protocol is required in the event the patient needs to be referred to an acute care facility or emergency room. Further, there are a number of disclosures that must be made by providers using the online telemedicine platform – including fees, contact and license information of the doctor and a method for patients to give feedback and to access and amend their patient records. The domain name must accurately reflect the online provider’s identity. The Model Policy further cautions doctors should not benefit financially from linking to other websites from online platforms (i.e., “pay per click” arrangements).

As an example, the New York Department of Health has issued a statement that follows much of the guidance set forth in the Model Policy, including as it relates to standard of practice, patient location, development of physician-patient relationship and medical records. However, the practice of telemedicine is more broadly characterized as follows:

• The geographic separation between two or more participants and/or entities engaged in health care,
• The use of telecommunication and related technology to gather, store and disseminate health-related information, and
• The use of electronic interactive technologies to assess, diagnose and/or treat medical conditions.

It should be noted that New York does not have a statute or regulation that expressly prohibits the prescription of medication without a prior physical exam, as do other states.

California and Florida have specifically enacted telemedicine laws. The California Business and Professional Code requires a full medical license to practice medicine. California does not have specific language within its state statute, nor its administrative regulations, granting doctors a “special/limited” license to enter the state remotely to practice telemedicine. Further, the administration of medication over the Internet for delivery to any person in this state without a prescription issued pursuant to a good faith prior examination of a human . . . for whom the prescription is meant . . . ; Cal. Bus. & Prof. Code § 4067(a).

Additionally, the California Business and Professional Code § 2242(a) generally prohibits as “unprofessional conduct” the “[p]rescribing, dispensing, or furnishing dangerous drugs . . . without a good faith prior examination and medical indication thereof.”

Similarly, the Florida Board of Medicine has promulgated a telemedicine regulation that states:

Prescribing medications based solely on an electronic medical questionnaire constitutes the failure to practice medicine with that level of care, skill, and treatment which is recognized by reasonably prudent physicians as being acceptable under similar conditions and circumstances. . . . Florida Admin. Code § 64B8-9.014(1).

Florida’s regulations, however, do provide an exception that might be utilized as a basis for long-distance care. It states that the above regulation:

[S]hall not be construed to prohibit patient care in consultation with another physician who has an ongoing relationship with the patient, and who has agreed to supervise the patient’s treatment, including the use of any prescribed medications, nor on-call or cross-coverage situations in which the physician has access to patient records. Florida Admin. Code § 64B8-9.014(4).

This exception to the Florida regulation may provide a basis to act in consultation by an out-of-state doctor with a local physician, but will not permit a doctor directly to treat patients across the border in Florida from another state. Additionally, Florida has extensive pharmacy laws that prohibit pharmacists and pharmacies from dispensing medications where it is known there is not a proper physician-patient relationship. Florida Statute § 465, et seq.

Accordingly, California and Florida are two of the many examples where doctors are restricted from conducting telemedicine and from treating patients on a long-distance basis where there is not a proper prior history and physical examination of the patient.

New Jersey does not have any specific regulations or statutes that address telemedicine specifically. The general rule in New Jersey, as in most of the other states, is that physicians engaging in telemedicine with New Jersey patients must be licensed in New Jersey. N.J.S.A. § 45:9-6. There are two small

continued on page 10
exceptions to the general rule, found in N.J.S.A. § 45:9-21(b)-(c). Of relevance is subsection (c) which allows a physician or surgeon of another state of the United States that is duly authorized under the laws of that state to practice medicine or surgery there, is not required to obtain a license in New Jersey if the practitioner does not open an office or place for the practice of his profession in this State. Despite this exception, N.J.A.C. §§ 13:35-7.1A and -7.5 indirectly impact upon telemedicine as these regulations require physical examinations of patients prior to dispensing or prescribing drugs to them. Accordingly, this would place a limitation on the ability of a physician to practice via telemedicine at least as it relates to treatment of patients through drug therapy within New Jersey. In addition, with regard to interpretation of any diagnostic testing, the provisions of N.J.A.C. § 13:35-2.76(s) permit a New Jersey physician to transmit records or data for interpretation by a consultant who is not a New Jersey licensee provided that written consent to such interpretation service is obtained in advance from the patient and any third-party payer. By its terms, “this subsection is intended to be available for special occasional or emergent consultations only.” Providing such diagnostic interpretative services during the course of a year on 10 or more occasions “is deemed to be rendering medical services in this State and requires licensure by the Board.” While this regulation is directed at diagnostic testing, the New Jersey licensing board might take a similar stance on actual treatment encounters.

Further, based on an analysis similar to the court’s in Allstate Ins. Co. v. Northfield Medical Center, P.C., 2001 WL 34779104, *37 (N.J. Super. Ct. Law Div., April 27, 2001), it is possible that both the medical board and third party payors may take a strict view of a foreign doctor’s activities in New Jersey. Recognizing N.J.S.A. § 45:9-21(c)’s exception to the prerequisite of licensure in New Jersey, the court nonetheless stated in dicta that even if an out-of-state doctor does not have an in-state office, he or she may still need to be licensed in New Jersey “before engaging in regular practice . . . because it is the state government which retains the authority to protect the public by disciplining an incompetent, negligent, impaired or dishonest practitioner.” (Emphasis added). The court emphasized throughout the opinion that if one practices medicine regularly in NJ, even though they may be licensed in a different state and not have an office here, the exception would not apply to them because New Jersey has an interest in protecting its citizens and the Board of Medical Examiners still has a right to regulate the doctor. Hence, there is a risk that consulting and treating patients regularly in New Jersey may prompt the requirement to obtain licensure here despite the exception found in the statute.

The General Consensus. The trend suggests two critical requirements in many states for telemedicine. First, the doctor generally must be licensed in the state in which the patient resides, regardless of where the doctor is located. Second, the doctor must conduct an appropriate and sufficient history and physical examination of the patient as a precondition to prescribing or dispensing drugs to the patient. In many ways, these two common requirements place a tremendous barrier on the practice of telemedicine across state borders.

Thus, while telemedicine may be progressing, there are still significant barriers and limitations that would make use of this technology challenging. In particular, to fully and independently conduct the of medicine, an out-of-state doctor would still need to obtain licenses in, or be subject to the jurisdiction of, the state where his/her patients reside, comply with and know the physician licensing laws in each of those states, pay the licensing fees in each state (if applicable), subject himself/herself to regulatory oversight and disciplinary enforcement in each of those states, be subject to the continuing medical education credit requirements of those states, and potentially subject himself/herself to medical malpractice liability in those states (also requiring malpractice insurance coverage for each such state). Further, the basic in-person patient examination requirement of some states to dispense drugs is not avoidable. Accordingly, telemedicine as a model for direct physician-patient communications has significant hurdles. As state legislatures get more comfortable with the concept of telemedicine, protections of transmission of patients’ information are further developed, and benefits of telemedicine are more closely appreciated, the future may be a friendlier environment for practitioners of telemedicine. For now, all need to be cautious of the risks involved.

About the Author
Cecylia K. Hahn is an associate in the health care practice of McElroy, Deutsch, Mulvaney & Carpenter, LLP, with twelve offices in New Jersey, New York, Connecticut, Massachusetts, Pennsylvania, Delaware, and Colorado.

Endnotes
2The Model Policy does not apply to the use of telemedicine when solely providing consulting services to another physician who maintains the physician-patient relationship with the patient who is the subject of the consultation. http://fsmb.org/Media/Default/PDF/FSMB/Advocacy/FSMB_Telemedicine_Policy.pdf.
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*Information. Not Intuition.*
**What’s In Your Beach Bag?**

NJ HFMA Members share their personal and professional reading picks

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**Recommended by** Chris Dalton, Executive Director, Business Operations, Surgem

*Parcells* – A great book for any NY Giant fan with a ton of great football coaching history. Parcells grew up in Bergen County and has deep roots in the area. Also a lot of great leadership things to learn, also techniques NOT to employ!

**Recommended by** Sally Cummings, Englewood Hospital & MC

*The Girl on the Train*  
*An Amazon Best Book of the Month, January 2015:* Intersecting, overlapping, not-quite-what-they-seem lives. Jealousies and betrayals and wounded hearts. A haunting unease that clutches and won’t let go. All this and more helps propel Paula Hawkins’s addictive debut into a new stratum of the psychological thriller genre. At times, I couldn’t help but think: *Hitchcockian.* From the opening line, the reader knows what they’re in for: “She’s buried beneath a silver birch tree, down towards the old train tracks…” But Hawkins teases out the mystery with a veteran’s finesse. The “girl on the train” is Rachel, who commutes into London and back each day, rolling past the backyard of a happy-looking couple she names Jess and Jason. Then one day Rachel sees “Jess” kissing another man. The day after that, Jess goes missing. The story is told from three character’s not-to-be-trusted perspectives: Rachel, who mourns the loss of her former life with the help of canned gin and tonics; Megan (aka Jess); and Anna, Rachel’s ex-husband’s wife, who happens to be Jess/Megan’s neighbor. Rachel’s voyeuristic yearning for the seemingly idyllic life of Jess and Jason lures her closer and closer to the investigation into Jess/Megan’s disappearance, and closer to a deeper understanding of who she really is. And who she isn’t. This is a book to be devoured. -Neal Thompson

**Recommended by** Cindy Biggio, Patient Accounting Director, Virtua Health

*Pleasure* – *The Girl on the Train* – NY Times Best Seller. Just finished reading it. It is quick to read, thrilling, good, and the ending was great.

*Business* – *Good to Great* – I just started reading this. Had the book but then read in Beckers that this is the #1 book that CEO’s recommended to read. So far it is inspiring and thought provoking.

**Recommended by** Brian Herdman, CBIZ KA Consulting

*Ready Player One*, by Earnest Cline is on my reading list. I’ve had many friends who are into sci-fi recommend it to me. When I asked what it’s about, the response is some version of “just read it”. So, I’ll read it.

*The Martian*, by Andy Weir

This enjoyable read has been compared to *Apollo 13, Robinson Crusoe, Cast Away,* and *MacGyver,* and continues to rank in the Amazon Top 10 despite being out for more than a year. The story follows a botanist, Mark Watney, who is left behind after an emergency evacuation of a Martian research habitat. Watney’s ingenuity and wit are chronicled in great detail, giving this reader all the more reason to hope for his survival. Read this book now before the movie comes out this fall.

**Recommended by** Christine Gordon, Manager of Reimbursement/ Budget & Reimbursement Dept., Virtua

*’Another Cutter’* by David E. Gordon – My husband has written his second suspense novel (in his spare time.) The book is about a self-made billionaire who has fortune, family, love…secrets, hidden pasts and dangerous liaisons.

*“Outlander”* by Diana Gabaldon – This book was written almost 25 years ago but is seeing a resurgence with a new popular TV show. It’s about a 20th century nurse who travels back in time to 18th Century Scotland and finds romance and adventure with a Scottish Highlander.

**Recommended by** John Dalton

Since taking the glide path from full employment to semi-retirement to my present status, I’ve had more discretionary time to pursue my interest in American history. I began in 2003 with Perry Ellis’s “1776,” and for the past year have been immersed in the first half of the 20th century. I’m old enough to recall air raid warnings, blackout curtains, ration books and V-E Day. For those interested in American history, there are four books I would unequivocally recommend:
“Dead Wake: the Last Crossing of the Lusitania,” by Erik Larson. I’ve read several of Larson’s books, including “Isaac’s Storm: a Man, a Time and the Deadliest Hurricane in History.” The story of the 1900 Galveston hurricane, two weeks before Superstorm Sandy interrupted our lives. Larson is a master of capturing historical events through the eyes of participants and “Dead Wake” is no exception. Few heroes, many villains, including (perhaps) Lord of the Admiralty Winston Churchill. Larson skillfully mixes Lusitania passenger stories with that of the German U-boat. There is wide speculation that the Brits allowed the 1915 sinking of the Lusitania off Queenstown (Cobh) in their zeal to draw America into the Great War since nearly 200 Americans were on board. Their strategy failed, as President Woodrow Wilson was romancing Edith Galt who became his second wife (and acting President after Wilson’s stroke, if the stories are to be believed). The flagship of the Cunard Lines sunk in 18 minutes.

“The Boys in the Boat: Nine Americans and Their Epic Quest for Gold at the 1936 Berlin Olympics.” Most Americans are familiar with the story of Jesse Owens, whose gold-medal winning performance at the 1936 Berlin Olympics flew in the face of Chancellor Adolf Hitler’s vision of an Aryan master race. Few are aware of the enormous hurdles the boys in the boat from Washington had to overcome, first to qualify for the Olympics, then to compete under adverse circumstances. There is a mix of personal back stories with the technicalities of rowing an eight-man scull, but the final chapters are gripping. It will make you proud to be an American.

“Eisenhower in War and Peace” by Jean Edward Smith. Personally, I rank Ike as one of the top 3 Republican presidents, along with Abraham Lincoln and Theodore Roosevelt. To many young Americans, Eisenhower is an obscure figure. Smith’s book presents a detailed look at Ike’s public and private life. From his service during the period between the two World Wars through his ascendency to Supreme Commander of the Allied Forces in Europe, his Presidency of Columbia University and his presidency, Smith’s book is readable and evocative of one of our most underrated Presidents. All Ike did was to end the Korean “police action,” implement the Interstate Highway System and produce eight years of peace and prosperity.

I read Richard Reeves’s latest book, Infamy: the Shocking Story of the Japanese-American Internment in World War II,” over the Memorial Day weekend. I’ve read several of his books and, until now, had considered “President Nixon: Alone in the White House” as his masterpiece. In my inexpert opinion, it’s the best book ever written on that troubled President. Infamy is a masterpiece that should rank alongside works like “Bury My Heart at Wounded Knee” for clearly articulating Americans inhumanity to their fellow Americans. Reeves has have connected those dots like none before him, although giving generous credit to those who tried. The World War II internment of 120,000 Japanese-Americans in isolated concentration camps remains the greatest stain on President Franklin D. Roosevelt’s otherwise stellar record. Meticulously researched, Infamy documents the post-Pearl Harbor panic and paranoia that led to Executive Order 9066, and there are villains aplenty, including California Attorney General Earl Warren (subsequently Chief Justice of the U.S. Supreme court), Deputy Secretary of War John McCloy (subsequently Chairman of the World Bank) and even cartoonist Theodor Geisel (better known as Dr. Seuss). In some ways, it was not unlike the anti-Muslim anger following 9/11, but carried to an unconstitutional extreme. McCloy’s quote “if it is a question of the safety of the country and the Constitution…why the Constitution is just a piece of paper to me.”

By putting a human face on the tragedy, Reeves has produced the most readable account of this travesty of justice. Whether it was Seattle shopkeepers forced to sell their businesses for pennies on the dollar, San Pedro fishermen forced to abandon their boats, or Oregon farmers forced to leave their homes and farms behind, “military necessity” drove them to imprisonment behind barbed wire and guard towers in concentration camps located in barren deserts and remote swamps.

Despite their maltreatment, most internees remained loyal to their adopted country. When finally allowed to enlist in the Army in January 1943, the 442nd Regimental Combat Team fought fiercely in the European Theater of Operations, becoming the most decorated unit per capita of the Second World War. Reeves tells the amazing story of their rescue of “The Lost Battalion,” a Texas National Guard unit that had been cut off and surrounded by German troops. Reeves weaves in the stories of Daniel Inouye, Medal of Honor winner and long-term Senator from Hawaii, and Norman Mineta, Congressman and cabinet member in both Democratic and Republican administrations.

The injustice that Caucasian Americans perpetrated on 120,000 fellow citizens, placing them in concentration camps and stealing their possessions, is one of those sins that cries out to heaven for vengeance. This quote from Chapter 9 says it all: “When Private Shiro Kashino…first saw the row of huts behind barbed wire at Dachau, he said, ‘This is exactly what they had built for us in Idaho.’” Unfortunately, the racial paranoia depicted in Infamy continues to prevail today. Infamy is a tale that celebrates the ability of the human spirit to ultimately transcend adversity. It’s a compelling read!

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

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<td>AtlantiCare</td>
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<td>VP Finance</td>
<td>Barnabas Health Care System</td>
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<td>Director of Revenue Cycle</td>
<td>Ambulatory Surgical Consultants</td>
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<td>Barnabas Health</td>
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CMS issued a final rule on June 4 revising the Shared Savings Program for Accountable Care Organizations (ACOs). The rule changes several program areas, including beneficiary assignment, data sharing, available performance risk models, eligibility requirements, participation agreement renewals, and compliance and monitoring. This came on the heels of the CMS Innovation Center’s introduction in March of the “Next Generation ACO Model,” which built on its earlier Pioneer Model with the potential for more advanced integrated systems to take on more risk (and reward) than under the last generation.

Where have ACOs been, and where are they going in New Jersey?

ACOs mean different things to different people, but in Medicare’s world, ACOs are groups of health care providers who come together to give coordinated care to their Medicare patients. They serve enrollees in traditional fee-for-service Medicare – not Medicare Advantage. Enrollees are therefore free to use any providers participating in the Medicare system without regard to their affiliation with the ACO.

For the most part, participants in the Medicare ACOs continue to get paid as under traditional Medicare fee-for-service. They are held to specific quality measures, and, if that quality care costs the Medicare Program less than CMS would have expected to pay absent the ACO, the ACO participants can share in some of the savings. Depending upon the model, they can also share in losses.

To some, ACOs are the wave of the future. In January, HHS Secretary Burwell announced a goal of basing 50 percent of Medicare payments on the quality of care provided, not on volume, by 2018. How can one sit on the sidelines? To others, they are an unsustainable flash in the pan. Rewards are based on savings that would not have occurred in the absence of the ACO for that beneficiary group. Once you have achieved a high level of efficiency, how could you continue to reap savings?

Medicare ACOs got a shot in the arm when Section 3022 of the ACA required the Secretary of HHS to establish the Medicare Shared Savings Program, to encourage the development of ACOs in Medicare. The original regulations established two tracks for ACOs – a one-sided model under which the ACO shares only in some of the gains, above a threshold, and a two-sided model under which the ACO shares in gains or losses above a specified corridor, and within limits. Of course, under either model the ACO has to make a substantial investment in infrastructure.

The stated goal was always to move ACOs to a two-sided model, and the original regulations anticipated that the one-sided model would not be available after the first agreement period. Entrants into the ACO arena stayed away from the two-sided model in droves, however. A CMS fact sheet with data as of January 1, 2015 shows 401 ACOs in the one-sided model, and only three (3) in the two-sided model. In New Jersey, 17 organizations have formed Medicare ACOs since 2012, all in the one-sided model.

Medicare ACOs have also been a springboard to commercial insurance arrangements. A Robert Wood Johnson Foundation Report released in June, “Recent Changes in Primary Care Delivery and Health Provider Systems in New Jersey,” showed that 11 of the 17 New Jersey ACOs also had ACO activity with commercial plans. A CMS-sponsored study said the majority of Pioneer ACOs reported experiencing pressure from private and public purchasers to engage in risk-based payment contracts, including establishing accountable care-like delivery models. United Healthcare recently announced its intention to expand its base of accountable care contracts across its employer-sponsored, Medicare and Medicaid health benefit businesses, anticipating that, by 2017, reimbursements to hospitals, physicians and ancillary care providers will be paid through contracts linking reimbursement to quality and cost-efficiency measures will account for $50 billion in expenditures.

On the Medicaid side, in August 2011, Governor Christie signed into law P.L. 2011, Chapter 114, requiring the Division of Medical Assistance and Health Services to establish a three-year Medicaid Accountable Care Organization (ACO)
continued from page 15

demonstration project. Seven coalitions of healthcare providers in different areas of the state have applied to be a part of the program. Three were approved at the end of June.

Absent a severe change in direction, then, provider organizations that want to participate in ACOs (or are nudged by changing reimbursement models) will have to look seriously at risk-bearing models, and all that entails under Federal and State rules. To understand New Jersey laws that apply to (non-insurer) risk-bearing entities, it’s necessary to delve into the somewhat bumpy history of alternative health care financing and delivery models in New Jersey.

Risk-Bearing Intermediaries in New Jersey

The concept of health care providers bearing risk is as old as capitation itself. If a doctor agrees up front to accept a fixed amount per member per month to provide a level of services he or she can’t predict with certainty in advance, that’s a level of risk-bearing that every capitated doctor assumes. For facilities, agreeing to provide services at a fixed per diem amount or for a diagnosis-related group creates the risk that services will be required that cost more to provide than the per diem or DRG rate covers. But these are levels of risk we assume providers can handle.

Risk-bearing is taken to a whole new level, however, when another entity is created separate and apart from the health care practitioner or facility, and that entity undertakes to manage the risk of multiple health care practitioners and/or facilities. That starts to look more like the business of insurance.

New Jersey Supreme Court Justice Jaynee LaVecchia (when she was the Commissioner of the New Jersey Department of Banking and Insurance), once had this to say on the subject:

“I have a significant concern about arrangements which transfer risk to unlicensed entities. First, the unknown financial viability of the unlicensed entities exposes the public to risk of failure that may result in, among other things, a consumer losing access to health care services or being responsible for large unpaid bills. Two, the quality of care is of concern when quality assurance and utilization review functions are subcontracted to a non-licensed entity that is not subject to regulation. Three, continuity of care for an individual is not guaranteed if the unlicensed entity fails or the contract is terminated.”

The Commissioner had ample cause for concern. The occasion for her remarks was the May 20, 1999 Senate Health Committee hearing on the causes of insolvency of HIP Health Plan of New Jersey (HIPNJ). HIPNJ had been the fourth largest HMO in New Jersey. The context for her remarks was an arrangement between HIPNJ and two unlicensed entities.

In July of 1997, HIPNJ sold most of its property and goodwill to PHP Healthcare Corporation (PHP), a for-profit Delaware corporation. At the same time, HIPNJ entered into a twenty year Health Service Agreement with Pinnacle Health Enterprises (PHE), a subsidiary of PHP, under which PHE undertook the delivery and administration of healthcare services. In return, HIPNJ paid PHE a capitation payment equal to 91.5% of premiums collected.

While the DOBI directly regulated the solvency of HIPNJ as a Health Maintenance Organization, it did not have the same authority over the unlicensed PHE, which maintained it didn’t need a license as it was not marketing directly to the consumer.

According to the Superior Court’s order liquidating HIPNJ: “PHE failed to meet its obligations to process claims and make timely payments to healthcare providers. The amount owed by PHE for medical services and supplies rose to approximately $120,000,000 despite having received capitation payments in excess of $300,000,000. As a result of PHE’s escalating debt, HIPNJ’s net worth correspondingly spiraled downward and continued to hemorrhage.”

Following the HIPNJ collapse, New Jersey passed a law establishing oversight by the DOBI of what the law refers to as “Organized Delivery Systems” (ODSs). In general, an ODS is an entity contracting with a carrier to provide comprehensive or limited services, but does not include any professional corporation, professional association or independent practice association (IPA), provided the shareholders are solely providers, and the entity performs no services beyond those for which its shareholders are otherwise licensed. An ODS must be either licensed or certified with the DOBI.

The question of whether an ODS needs to be certified or licensed depends upon whether the ODS assumes financial risk from the carrier. An ODS that assumes financial risk must become licensed, unless the Department determines the financial risk is de minimis, as set forth in regulation. An ODS that does not assume financial risk or that is determined to assume only a financial risk must become certified.

Whether an ODS is licensed or certified, it must meet certain minimum standards regarding the functions that the ODS intends to perform under contract with carriers. The standards are substantially similar to those that carriers would have to comply with if they were performing the specific functions themselves. For licensure, to bear risk, an ODS must satisfy minimum net worth and deposit requirements. To date, the DOBI website lists 12 licensed ODSs, and 50 certified ODSs.

During my tenure as the Assistant Commissioner for Life and Health at the New Jersey Department of Banking and Insurance, from March 2010 to March 2014, the sweet spot for ACA implementation, DOBI attempted to sort out some of this alphabet soup of State and Federal oversight of non-insurer risk-bearers by issuing a Bulletin in 2013 on the application of
state law to Alternative Health Care Financing and Delivery Models.¹

Pursuant to P.L. 2011, c. 114 (codified at 30:4D-8.1.), which established a Medicaid Accountable Care Organization Demonstration Project, a Medicaid ACO certified pursuant to that act is not required to obtain licensure or certification as an ODS while it is providing services to Medicaid recipients.

**The First Post-ACA Generations**

Two separate, but closely related CMS initiatives post-ACA were the broad-based Medicare-Shared Savings Program (MSSP), and the more narrowly-focused Pioneer Program.

On March 31, 2011, HHS released the proposed regulations for MSSP ACOs. As previously mentioned, there were two options with the MSSP: a shared savings-only model (Track 1) and a two-sided risk model (Track 2). In the Track 1 model, ACOs achieving a specified minimum savings rate can share in up to 50 percent of savings based on quality performance, and there is no downside risk for the three-year agreement period. For Track 2, ACOs that achieve a specified minimum savings rate can share in up to 60 percent of savings, but this model includes downside risk. ACOs not meeting the minimum savings rate will share in losses (also not exceeding 60 percent). Quality metrics are also required to be met. The final rules were published in the Federal Register on November 2, 2011.

On May 17, 2011, CMS announced the Pioneer Program, through its Innovation Center. CMS said this was intended for a limited number of larger organizations that already had proven risk-sharing experience. In the Pioneer Program, an ACO accepted into the program could bear greater risks and rewards than under the standard MSSP Program.

Because MSSP ACOs apply to enrollees in traditional fee-for-service Medicare, enrollees are free to use any providers participating in the Medicare system without regard to their affiliation with the ACO, which makes care management challenging. On the one hand beneficiaries are free to come and go, but the ACO is responsible for the care delivered to some fixed population. How do you define such a fluid cohort? CMS uses what it refers to as preliminary prospective beneficiary assignment, subject to a final retrospective adjustment. The beneficiaries ‘aligned’ with a particular ACO are identified prior to the start of a performance year on the basis of their historical utilization – those fee-for-service beneficiaries who received the larger amount of primary care services (or in certain circumstances, selected specialty care services) from physicians and other practitioners who participate with the ACO, compared to providers affiliated with any other ACO or any non-ACO-affiliated provider. To be eligible, an ACO needs at least 5,000 aligned beneficiaries. The retrospective adjustments apply when calculating the savings or loss, by removing beneficiary months from the performance period for beneficiaries who were not in the fee-for-service program the entire time.

The next step is to establish a benchmark for that cohort, to be used to measure success (or failure). The benchmark uses a formula that starts with a baseline of historic expenditures for that cohort, with some adjustments to trend claims to the last base year and remove some outlier data. Savings or losses are defined as the difference between the per capita expenditure benchmark for a year and the actual per capita expenditure for that year’s aligned beneficiaries.

To qualify for shared savings under the one-sided model, savings had to exceed a minimum savings rate, established on a decreasing sliding scale between 3.95 percent on the low end and two (2) percent on the high end. For the two-sided model, the cutoff is two (2) percent above or below the benchmark for shared savings or losses to apply.

New Jersey had 11 ACOs prior to 2015. While all met the quality metrics, only three of the 11 saved enough money to qualify for a shared savings payout. According to CMS, 19 ACOs participated in the Pioneer Program nationally, but none were in New Jersey, and that program is no longer accepting applications.

**2015 and the Next Generation**

Just as the original regulations were proposed in 2011, followed closely by the announcement of the Pioneer Model, revisions to the rules were proposed in December 2014, followed by the March 2015 announcement of “The Next Generation.”

The new rules change the program in a number of areas including:

- Allowing eligible ACOs to continue participation under the one-sided model for a second agreement period;
- Adding a new performance-based risk option (Track 3) that includes prospective beneficiary assignment and a higher sharing rate;
- Establishing a waiver of the 3-day stay SNF rule for beneficiaries who are prospectively assigned to ACOs under Track 3;
- Increasing the emphasis on primary care services in the beneficiary assignment methodology, including counting more services performed by non-physician practitioners;
- Streamlining data sharing between CMS and ACOs for beneficiaries who do not opt out of data sharing;
- Providing ACOs a menu of choices of symmetric thresholds for savings and losses under the two performance-based risk tracks;
- Refining the methodology for resetting benchmarks, including weighting the benchmark years evenly instead of giving more weight to the recent years, and crediting ACOs for savings generated in the prior agreement period.

*continued on page 18*
In publishing the final rule CMS indicated an intent to propose another rule later this year further refining the benchmark based in part on trends in regional fee-for-service costs rather than solely on the ACO’s own recent spending.

The Next Generation program would launch in January 2016 and expand the following year to reach a total of 15 to 20 accountable care organizations, according to CMS. Like the Pioneer Model, it is intended for a limited number of larger organizations that already had proven risk-sharing experience.

Unlike the Pioneer Model, the Next Generation does not have a minimum savings rate. Instead, CMS applies a discount to the benchmark (after the baseline is calculated, trended, and risk adjusted). The discount is a function of the ACO’s quality score, regional efficiency and national efficiency, with a total range of between .5% and 4.5%.

Two risk arrangements are available under the Model – Increased Shared Risk (80% in early years, 85% later) and 100% Risk. Both incorporate a cap on savings and losses of 15% of the benchmark. To be eligible for participation in the Next Generation Model, ACOs must maintain an aligned population of at least 10,000 Medicare beneficiaries (7,500 for designated Rural ACOs).

The Next Generation Model also offers four different payment mechanisms – capitation, fee-for-service, FFS plus a per-beneficiary per month payment, and population-based payments.

It is not necessary to have participated in the Pioneer ACO or Medicare Shared Savings Program to apply for the Next Generation Model.

The Next Generation Model will have two application rounds – the first due date was June 1, 2015 for a 2016 launch, and the second will be June 1, 2016 for a 2017 launch.

Will New Jersey health care providers and systems embrace the new ACO options, including the assumption of down-side risk? Time will tell, but prudence dictates they will have to be watched closely, and serious entrants must follow the rules for establishing risk-bearing entities in the State of New Jersey.

About the Author

Neil M. Sullivan, Esq. is a partner with McElroy, Deutsch, Mulvaney & Carpenter, LLP where he practices healthcare and insurance law. Mr. Sullivan served as Assistant Commissioner of the New Jersey Department of Banking and Insurance, overseeing the Office of Life and Health, from 2010 to 2014. Mr. Sullivan can be reached at nsullivan@mdmc-law.com.

Endote

1http://www.state.nj.us/dobi/bulletins/blt13_04.pdf
SCOTUS Once Again Saves the Affordable Care Act

By James A. Robertson, John W. Kaveney and Cecylia K. Hahn

On June 25, 2015, in a highly anticipated decision, the Supreme Court of the United States issued a ruling in King v. Burwell holding that tax credits available to some taxpayers under the Affordable Care Act (“ACA” or “Act”) to help subsidize their health insurance costs would be available to individuals living in all 50 states regardless of whether the state is operating under a State or Federal Exchange. Many have heralded the decision as saving the President’s legislation by protecting a key cornerstone of its ability to ensure affordable health insurance for the poorest individuals. While the Supreme Court has now saved the legislation twice, many experts believe the challenges to various aspects of the ACA will only continue in the future.

I. Why Is the Supreme Court’s Decision in King v. Burwell so Critical?

The ACA combines three specific reforms that provide the foundation of this legislation and the hope of affordable health insurance for all Americans. First, the ACA adopts guaranteed issue and community rating requirements. These requirements disallow insurers from denying coverage or from raising the cost of coverage to any person because of his or her health. Second, through the individual mandate, the ACA requires individuals to either purchase health insurance or pay a tax to the IRS. The goal of the individual mandate, in combination with the other reforms included in the ACA, is to make health insurance premiums more affordable by encouraging populations to purchase health insurance before they become ill and thereby creating a more favorable risk pool. Third, in the spirit of trying to make health insurance more affordable, individuals with household incomes between 100 and 400 percent of the federal poverty line are provided refundable tax credits to help offset the cost. These three reforms are intended to work together to increase the number of individuals covered by health insurance and simultaneously lower the cost of health insurance nationwide.

To facilitate the purchase of health insurance as required by the individual mandate, the ACA also requires the creation of an Exchange in each state. Section 1311 of the ACA mandates that each state provide an Exchange for the purchase of health insurance within that state. Section 1341 of the ACA provides that the Secretary of Health and Human Services is responsible for creating and operating Exchanges in states that do not establish their own Exchanges.

The issue in King v. Burwell was whether individuals purchasing insurance in states with Federal Exchanges were entitled to the same tax credits as individuals residing in states operating a State Exchange given the language in the ACA that state tax credits will be available to taxpayers enrolled in an insurance plan purchased through “an Exchange established by the State under Section 1311” of the ACA. Thus, with approximately 29 of the states not operating their own exchange and instead leaving it to the government to run a Federal Exchange, a significant percentage of the indigent population was left with the possibility of not receiving tax credits essential to affording health insurance.

II. How Did the Supreme Court Reach Its Decision?

Section 36B of the Internal Revenue Code provides that tax credits are allowed for any “applicable taxpayer” and the determination of the amount of the tax credit partially depends on the taxpayer’s enrollment in an insurance plan purchased through “an Exchange established by the State under Section 1311” of the ACA. The Rule promulgated by the IRS in response to this statutory section makes no distinction between...
continued from page 19

an Exchange established by the State and one operating under the control of the Secretary of Health and Human Services. In King v. Burwell, the petitioners challenged the validity of the IRS treating Federal and State Exchanges as synonymous, and instead, argued that based on Section 36B, tax credits were meant to be available only to individuals who purchase health insurance on State Exchanges. Residing in a state that did not create its own Exchange, the petitioners did not wish to have access to the credit because it would legally deem health insurance affordable for them thereby mandating its purchase, which they preferred not to do.

The Supreme Court held that Section 36B’s tax credits are available both in states that have State Exchanges and states that have Federal Exchanges. The Court opined that the tax credits are “among the Act’s key reforms, involving billions of dollars in spending each year and affecting the price of health insurance for millions of people.” Thus, whether or not they are available on Federal Exchanges is a question of such political and economic significance, and is so central to the statutory scheme of the ACA, that had Congress wanted to assign authority to make that decision to an agency, it would have done so explicitly. Further, the Court pointed out that it would make little sense to delegate such a question to the IRS given that it is an agency with no experience creating health insurance policy.

Thus, the Court felt it was best suited to determine the meaning of the provision by considering both the language and the context of the overall statutory scheme. After examining the language of Section 36B and other provisions of the ACA, the Court found that the phrase “an Exchange established by the State under [42 U.S.C. §18031]” was ambiguous; it could be interpreted to reach only State Exchanges or it could be interpreted to additionally reach Federal Exchanges. Although simply reading the words of the specific provision in the statute would seem to indicate that only State Exchanges should be included, reviewing the context of the Act, the Court found several reasons that such an interpretation would not make sense. First, the Act uses the phrase “an Exchange established by the State under [42 U.S.C. §18031]” where it would make no sense to distinguish between State and Federal Exchanges. Additionally, the ACA instructs the Secretary to establish “such Exchange” where the State has not done so. The Court interpreted this language to mean that there would be no fundamental differences between a State Exchange and a Federal Exchange. (However, some believe that if tax credits were available only to those operating through State Exchanges, there would indeed be a fundamental difference created.) The Court also pointed to several provisions that it concluded assume that tax credits would be available through both types of Exchanges, such as Section 18031(i)(3)(B)’s requirement that all Exchanges create

outreach programs to convey “fair and impartial information concerning . . . the availability of premium tax credits under Section 36B” (which would make little sense if tax credits were not available on Federal Exchanges). Petitioners argued that Section 36B was unambiguous because the words “established by the State” would be unnecessary had Congress intended the tax credits to be available on both the State and Federal Exchanges. The Court dismissed this argument, explaining that because the ACA was drafted and passed through reconciliation, limiting the opportunities for amendment and debate, the Act does not reflect the care in drafting that would be expected of such significant legislation.

After determining the text to be ambiguous, the Court next turned to the structure of the Act to determine the meaning of Section 36B. It found that accepting the petitioners’ interpretation of the Act and holding that the tax credits are only available to those purchasing health insurance on a State Exchange would “destabilize the individual insurance market in any State with a Federal Exchange, and likely create the very ‘death spirals’ that Congress designed the Act to avoid.” Because the three reforms integrated into the ACA only operate well in tandem, the Court held that to find the tax credits apply only in states operating on State Exchanges would be to disregard the spirit of the law. The Court pointed out that accepting the petitioners’ interpretation of the statute would mean that close to 87 percent of people who bought insurance on a Federal Exchange would become potentially exempt from the individual mandate (due to the affordability requirements), thus pushing States’ individual insurance markets into the ‘death spiral’ the ACA was designed to combat. According to the Court, “it is implausible that Congress meant the act to operate in this manner.”

For these reasons, the Court held that it was compelled to “depart from what would be the most natural reading of the pertinent statutory phrase.” In conclusion, the Court opined that Congress’ intent in passing the ACA was not to destroy health insurance markets, but to improve them, and the responsibility of the Court was to interpret, if possible, the Act in a way consistent with improving the markets.

III. Why Were Some Justices Critical of the Decision?

In his dissent, Justice Scalia accuses the Court of ignoring the normal rules of statutory interpretation in order to save the ACA. He, unlike the majority, interpreted other parts of the ACA to “sharply distinguish between the establishment of an Exchange by a State and the establishment of an Exchange by the Federal Government.” He points out that their authority to establish Exchanges come from different provisions, as does the authority for funding the Exchanges. He also references the fact that the phrase “by the State” is included throughout
the ACA and that the Court’s interpretation instructs readers to ignore this phrase as it appears throughout the entire Act.

According to Justice Scalia, Section 36B is unambiguous, thus, statutory design and purpose should play no role in the Court’s reading of the statute. Justice Scalia recognized the potential instability that excluding the tax credit for those operating through Federal Exchanges could create as a flaw in the statutory scheme, not a reason to hold that the “statute means the opposite of what it says.” Justice Scalia best summed up his position regarding the lengths to which he felt the Court went to save this legislation by claiming that everyone should start calling it “SCOTUScare” rather than the commonly used “Obamacare.”

Justice Scalia concluded his dissent by pointing out that this is not the first time the Court has transformed the ACA to make it work better and warned that in the future “the somersaults of statutory interpretation [the Court] has performed will be cited by litigants endlessly, to the confusion of honest jurisprudence.” Thus, he warned that the unique legal application applied here would likely be applied by advocates in future cases to circumstances much less desirable than the outcome manufactured here.

IV. What Is the Political Fallout of the Decision and Will There Be More Challenges?

Immediate reactions to the decision from those in the healthcare field have been more positive than negative. Many, including Bruce Siegal, M.D., President and CEO of America’s Essential Hospitals, praised the Court’s ruling, pointing out that deciding this case any other way would mean that six million Americans would lose their health insurance coverage. Those working in the healthcare industry, including Scott P. Serota, President and CEO of Blue Cross Blue Shield Association, point out that the resolution of this decision allows those in the healthcare industry to move forward with pursuing other strategies to make health insurance become even more affordable. And John Arensmeyer, founder and CEO of Small Business Majority, explains that the Supreme Court’s decision protects millions of small business owners, employees, and self-employed freelance entrepreneurs from losing health insurance pointing out that “employment and access to affordable health insurance historically have been tightly linked. That linkage pressures individuals to seek out and remain in jobs that provide affordable health insurance, even if they would otherwise choose to start their own business or pursue a more attractive job opportunity with a growing small business.”

Thus, for the ACA to have any future success, this was the necessary decision and those in the industry have recognized what it will mean to many Americans.

The reactions, however, have not all been positive as some commentators have suggested that more challenges to the ACA are likely to arise in the future. According to Avalere Health, in Washington D.C., “Congress may still pursue strategies to alter the Affordable Care Act, and the debate over reform is likely to reignite as part of the 2016 presidential race.” This is especially true given that many are still not convinced that the ACA is the ideal reform to ensure affordable insurance to Americans for the sustainable future. Thus, while Senate Democrats have taken the ruling as a sign to stop wasting time trying to repeal the law and move on to addressing other pressing issues, Republican presidential hopefuls have begun to weigh in on the ruling, which is likely to once again be an issue in the upcoming presidential election. Rick Perry responded by saying that it is not the responsibility of the Supreme Court to knock down the law, but instead, that “we need leadership that understands a heavy-handed, one-size-fits-all policy does nothing to help health outcomes for Americans.” Mike Huckabee, on the other hand, called the ruling “judicial tyranny” and expressed outrage at what he described as the Supreme Court “legislat[ing] from the bench, ignor[ing] the Constitution and pass[ing] a multitrillion-dollar ‘fix’ to ObamaCare simply because Congress misread what states would actually do.” Other Republican presidential hopefuls have responded similarly to the Supreme Court’s ruling, many expressing their agreement with Justice Scalia’s dissent.

Although common sentiment seems to be that this case is likely to be the last major challenge to the ACA that the Supreme Court will hear, issues related to the Act are still being decided in the lower courts. House Republicans are currently challenging $175 billion that the Obama administration is paying health insurance companies over ten years to reimburse them for offering lowered rates for people with lower incomes, arguing that Congress did not appropriate that money. Additionally, organizations owned by religious individuals are still attempting to challenge the compromise struck by the Supreme Court between allowing women under their health plans to obtain contraceptives at no extra cost and respecting the objections of such owners of organizations to providing contraceptives.

Thus, while the two major challenges to the ACA have been rejected by the Supreme Court, it appears that additional challenges are likely to continue occurring in the future as this massive legislation continues to be implemented. In any event, the ACA appears to be here to stay and only time will tell. continued on page 22
whether it will provide the sort of sustainable and affordable health insurance it has been created to provide or whether it will prove to be smoke and mirrors unable to effectively keep the cost of health insurance reasonable for Americans over the coming decades.

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Endnotes

2 26 U. S. C. §5000A.
3 26 U.S.C.S. § 36B.
5 42 U. S. C. §18051(c)(1).
8 Id.
10 Id. at 17.
11 Id. at 20.
13 Id. at 14.
14 Id. at 19.
15 Id. at 26.
16 Id. at 21.
18 Id.
19 Id.
20 Id.
### Who’s Who in NJ Chapter Committees

#### 2015-2016 Chapter Committees and Scheduled Meeting Dates

*NOTE: Committees have use of the NJ HFMA Conference Call line. If the committee uses the conference call line, their respective attendee codes are listed with the meeting date.*

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<th>CO-CHAIR/EMAIL/ PHONE</th>
<th>SCHEDULED MEETING DATES/*TIME</th>
<th>MEETING LOCATION</th>
<th>BOARD LIASON</th>
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</thead>
<tbody>
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High Deductible Health Plans: Increasing in Popularity with Consumers and What That Means for Hospitals

By Kevin Oakley

To date, the Affordable Care Act (ACA) has resulted in an estimated 32 million newly-insured Americans since 2010; nearly one-third of which purchased coverage through exchanges. On the surface, it appears that this would be nothing but positive news for health care providers, as their ability to collect for billed services should be enhanced with more insured consumers seeking care. However, taking a closer look at the plans the newly insured are choosing reveals a growing issue in collections for providers: the increasing popularity of high deductible health plans (HDHPs).

Users of the insurance exchanges and corporate consumers of health insurance are starting to shift their health plan choices toward higher deductible options. The tiered structure of offerings on the exchanges allows consumers to choose their plans based on cost. This is leading to an increase in popularity for HDHPs which typically include lower upfront premiums but higher total costs for many services. The number of HDHP enrollees rose to nearly 17.4 million in January of 2014, up from 15.5 million in 2013, 13.5 million in 2012 and 11.4 million in 2011; an average annual growth rate of approximately 15% since 2011.1 As consumer preferences shift further towards these HDHP offerings, the need for hospitals to adapt their billing and collection strategy increases; otherwise bad debt and charity care could evaporate profits.

Coinciding with the increasing interest of HDHP among consumers, more employers are offering HDHPs, and in some cases offering only HDHPs, to help control costs. This trend is expected to continue as companies react to the new laws governing their benefits and try to find ways to manage the increased cost of expanded coverage while avoiding penalties such as the “Cadillac” tax. The result is increased financial burden for patients and changes in their ability to pay and their willingness to forgo treatments due to cost.

Figure 1 demonstrates HDHP enrollment levels as a percentage of total enrollees, both on and off the exchanges. The data, collected by the U.S. Department of Health and Human Services and eHealth, Inc., captures both new and existing consumers of health care plans from the ACA open enrollment periods (Oct. 1, 2013 through March 31, 2014, and Nov. 15, 2014 through Feb. 15, 2015).

Silver, bronze and catastrophic plans contain deductibles that meet the IRS 2015 definition of HDHP. Of these new HDHP consumers, many are forgoing the typical mitigants for high deductibles such as health care savings accounts and flexible spending accounts. The consumers purchasing coverage on the exchanges are more likely to forgo savings accounts and in many cases are not even given the option. According to the National Center for Health Statistics, 36% of Americans under age 65 with private health plans are enrolled in an HDHP, and only one-third of those consumers are enrolled in plans linked to health savings accounts. With the out-of-pocket costs for patients increasing due to the popularity of HDHPs, and with so few purchasers taking advantage of savings plans, the risk of bad debts and charity care increases for health care providers.

As consumers become responsible for a greater portion of their health care costs, hospitals will see their role as collection.
agent grow. The need for an effective billing and collections department will result in increased overhead and more expenses for providers. Patients who receive services may be unable or unwilling to pay their high deductibles, putting further pressure on hospitals due to lost revenue from bad debts and charity care. Some patients may even go as far as deferring or avoiding preventative care, prescription medications and other treatments due to costs, resulting in even more lost revenue for hospitals.

**How are Hospitals Coping?**

Hope for hospitals is not lost, however. There are still benefits to the increased number of insured consumers and the preference for HDHPs is only another challenge for the industry as the effects of the ACA settle in. Many hospitals and systems have already started to put in place new programs and processes to offset some of the effects of HDHPs. Point-of-service collections, requiring whole or partial payment at the time of the appointment, are becoming an increasingly popular way for hospitals to collect payments for procedures and visits. Some providers are offering medical bill financing services, either directly or through partnerships with third-party banks and lenders. These services allow consumers to make smaller payments over time to control the burden of upfront costs, often for negotiated total amounts with little to no interest.

Most hospitals are placing an increased focus on their collections services by implementing new processes and programs to help improve billing and collections departments. Additionally, having discussions with the patient about costs throughout the entire treatment process is important. Many providers have found that focusing on communication and consumer education with regard to health care decisions, both treatments and coverage options, has created better results with both patient satisfaction and bill collection. In cases where costs to collect become too burdensome, there are an increasing number of outsourcing options that providers can consider.

With risks on the horizon due to the growth in HDHPs, it is time to revisit charity plans and examine how bad debts are treated. Charity care plans will need to start incorporating patients that technically have health insurance but are currently unable to afford the full deductible to pay for their care. Communicating with patients from the beginning of treatment plans can lead to a mutual agreement about payment plans and increase the likelihood of whole or partial collections. The billing discussions can lead to better budgeting on a per-patient basis and a more accurate forecast of charity care and bad debts. Forecasting, budgeting and managing the collections could be improved through separating the HDHP accounts from other insured patient accounts.

Guidelines should be established to determine how to set up payment plans, what incentives to offer, and how much of total cost could be forgiven. Identifying which patients qualify for income-based reductions, as well as those that would benefit from financing plans, can enhance efforts to recover outstanding billings. The more providers understand about their patient’s individual health care plans and financial situation early in the treatment cycle, the more accurately the provider can determine a collection plan and budget for discounts and assistance. Consideration should also be made to better define the distinction between charity care and bad debts. Providers will need to better understand and document what portions of outstanding statements are from HDHP patients, and when those amounts become bad debt and need to be written off.

**What Does this Mean for Financing?**

Because of the new challenges to revenue and collections in the health care space, lenders will become more focused on accounts receivable and census mix. Providers need to be aware of the shifting focus and make sure they are paying attention to those variables. Revenue management will be more closely tracked by ratings agencies, lenders and anyone looking at hospital credit. Historically, a lender’s focus on receivables has been on the aging schedule and net collections from the different payer sources. With the evolving landscape of insured private-pay patients, lenders will begin paying more attention to the charity care plans and analyzing bad debts. Being able to determine when a debt becomes uncollectable, distinguishing between the different types of payers and understanding the payment plan schedules will be an important conversation between lenders and providers.

Clear, defined processes and strategies regarding billing and collections from private payers have become essential for those involved in health care financing. It is important for providers to be aware of the challenges brought on by changes in health care plan preferences and to start implementing strategies to combat those risks.

**About the Author**

Kevin Oakley is an associate with Lancaster Pollard in Columbus. He is responsible for financial modeling and valuation, real estate assessment, credit analysis, interaction with all funding participants and coordinating the closing process. He earned his bachelor of business administration degree with emphasis in international economics from Marshall University and a master’s of business administration from the University of Notre Dame’s Mendoza College of Business. He is licensed through FINRA and MSRB, holding series 52 and series 79 certifications. He may be reached at koakley@lancasterpollard.com.

**Endnote**


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**Focus**

**Summer 2015**

25
Robert Wood Johnson University Hospital’s Sports Physical Therapy program has been giving back to the community. Their program helps athletes and their families see the benefits of stretching, strengthening, and prehab/rehab of injury. Physical therapists go on-site to swim meets to help keep the Somerset Valley YMCA swimmers healthy, and they have generously offered their services to help prevent worsening of injuries and aiding in recovery.

An average high school swimmer makes more than 1-2 million strokes with each arm every year. That puts these athletes at great risk for overuse injuries.

Shoulder impingement is one of the most common impairments for swimmers, due to the nature of the overhead shoulder motions involved with swimming.

Shoulder impingement develops when the rotator cuff tendons are overused or injured which can cause pain and motion impairments. Looking at the shoulder, the structures involved include the bony structures, the muscles, bursa and ligaments. The bony structures include the clavicle (collar bone), the scapula (shoulder blade) and the humerus (the bone of the upper arm). The muscles include those of the rotator cuff (the supraspinatus, infraspinatus, teres minor and subscapularis which attached from the scapula to the humerus) and those around the scapula including the serratus anterior, rhomboids and trapezius to name a few). The bursa is a fluid-filled sac below the acromion of the scapula and the ligaments help to keep the bony structures together.

The condition occurs as the muscles, ligaments and bursa can get compressed under the bony arch of the acromion. This can cause micro tears especially in the tendons, creating inflammation and pain with certain motions of the arm. If this continues and the athlete continues to irritate these structures, the shoulder may shut down all together and not allow overhead motion to occur.

In addition to swimmers, baseball pitchers and weight lifters can be susceptible to shoulder impingement due to repetitive overhead motions. It can also occur following an injury such as a fall, a congenital abnormality such as a hooked acromion, muscle tightness around the shoulder and a thickening of any of the structures that run under the acromial arch.

Symptoms of shoulder impingement include restricted shoulder motion, pain the shoulder or upper arm with movement and pain sleeping on the side of the involved shoulder. The condition is diagnosed by a thorough evaluation including a review of the client’s full medical history and some manual tests to evaluate the shoulder. There are some “textbook” signs and symptoms found through special tests and reviewing a subjective history with the client that allow us to diagnose the condition. Occasionally, x-rays or other diagnostic testing is needed.
Robert Wood Johnson University Hospital’s Sports Physical Therapy, has been working with Somerset Valley YMCA in Somerville to help their swim team prevent and rehabilitate sports injuries such as shoulder impingement, and has found the on-site approach works well.

Staff regularly attend swim meets to help stretch athletes before they swim to warm up their muscles and help identify and prevent any injuries. Several members of the Somerset Valley YMCA swim team have also undergone rehabilitation at one of Sports Physical Therapy’s locations to help them get back in top competitive form.

Physical therapists with Sports Physical Therapy have experience in a wide range of sports. This helps them understand not only their patients’ motivation and determination but also how their specific sport may play a role in their injury.

A number of different therapies are used to help patients. In addition to prescribing specific exercises, these may include hands-on soft tissue manipulation and trigger-point release. It may also involve guiding patients through proprioceptive neuromuscular facilitation (PNF) stretching, a technique in which patients can manually improve range of motion and strengthen and stabilize muscles.

Before therapy begins, the hospital’s therapists fully evaluate each patient. This evaluation drives the focus of therapy.

Therapists approach each patient from a full-body perspective. Often times, problems or restrictions elsewhere in the body create the problem. For example, a knee injury can actually be the result of foot or hip issues. The entire musculoskeletal system is evaluated to see how it functions to develop the best therapy for each patient.

Young athletes in any sport may benefit from a consultation with a physical therapist to identify and prevent overuse injuries.

About the Author
Jeff Erickson is the Assistant Director at Robert Wood Johnson University Hospital Sports Physical Therapy. He can be reached at Jeffrey.Erickson@RWJUH.edu.
I recently heard about the Clinton Foundation's failure to report foreign-sourced contributions on its Federal Form 990. Can you share more about this?

The Clinton Foundation has recently been in the news for allegedly failing to report foreign-sourced contributions on its annual Federal Form 990, Return of Organization Exempt From Income Tax, dating back to 2010. In a May 19, 2015 letter to Internal Revenue Service (“IRS”) Commissioner John Koskinen, Marsha Blackburn, R-TN, along with 51 other members of Congress, requested that the IRS review the tax-exempt status of the Clinton Foundation. It should also be noted that the Clinton Foundation retained the services of a professional certified public accounting firm to audit its financial statements and prepare its Forms 990 for these years.

The Clinton Foundation Background

The Clinton Foundation was established in 1997 in conjunction with former President Clinton’s vision of creating a nongovernmental organization that could leverage the unique capacities of governments, partner organizations and other individuals to address rising inequalities and deliver tangible results that improve people’s lives. Its mission is to improve global health and wellness, increase opportunity for women/girls, reduce childhood obesity, create economic opportunity and growth and help communities address the effects of climate change.

Form 990, Schedule B Reporting

Form 990, Schedule B, Schedule of Contributors, requires tax-exempt organizations to report detail with respect to certain contributions received by the tax-exempt organization that are reported in Form 990, Part VIII, Line 1. According to the Form 990, Schedule B instructions, a contributor (person) includes individuals, fiduciaries, partnerships, corporations, associations, trusts, and exempt organizations. In addition, Internal Revenue Code §509(a)(2), §170(b)(1)(A) (iv), and §170(b)(1)(A)(vi) state that organizations must also report governmental units as contributors. Contributions reportable on Schedule B include contributions, grants, bequests, devises, and gifts of money or property, whether or not for charitable purposes.

The Letter

In the Letter, Blackburn and her 51 colleagues cited two major issues surrounding the Clinton Foundation. First, they claim that the Clinton Foundation failed to accurately report foreign government grants received between 2010 and 2012. The Acting Chief Executive Officer of the Clinton Foundation responded by stating that “our error was that the government grants were mistakenly combined with other donations”. Former President Clinton expanded on this by stating that the omissions were “just an accident”.

Secondly, the Letter cited a Washington Post article dated May 3, 2015 which details the relationship between former President Clinton and Frank Giustra, both board members of the Clinton Foundation. The article indicates that Giustra has donated more than $100 million to the Clinton Foundation and that “Clinton has also gained regular transportation, borrowing Giustra’s plane 26 times for foundation business since 2005, including 13 trips where the two men traveled together”.

IRS Exempt Organization Monitoring

The IRS has increased its awareness of the activities of tax-exempt organizations in recent years. In order to facilitate its monitoring of these organizations, the IRS welcomes the public to file complaints, which are known as referrals, of any known activities in which organizations are abusing their tax-exempt status. These referrals are sent to analysts in the IRS Exempt Organizations Classifications Office in Dallas, Texas where the IRS issues an acknowledgement of receipt of the referral. The IRS is not permitted to disclose whether or not an examination has been initiated, nor can it reveal the re-
sults of an examination to any party other than the examined organization.

Concurrent with these guidelines, the IRS responded to the Letter with a form letter dated June 3, 2015 stating that “there is an ongoing examination program to ensure that tax-exempt organizations comply with the tax law and they will consider the submitted information within that program”.

**Conclusion**

The Clinton Foundation, along with all other tax-exempt organizations, need to be careful to include all necessary disclosures in their annual Form 990 filings in order to be compliant and avoid being questioned by the public or the IRS about the validity of their tax-exempt status. In addition, potential penalties exist for failure to accurately complete a Form 990. Even when a tax-exempt organization such as the Clinton Foundation engages a professional certified public accounting firm, reporting issues, or the lack thereof, can still arise.

**About the Author**

Allison S. Kimowitz, CPA, is a Supervisor at WithumSmith+Brown, Certified Public Accountants and Consultants, and is a member of the firm’s Healthcare Services Group. Allison can be reached at akimowitz@withum.com.

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**•Certification Corner•**

Hello. I hope everyone is enjoying the summer! I want to thank the Board for asking me to Chair the Certification Committee again for this upcoming Chapter year. We have some good things planned which should be helpful to those wanting to take the exam.

The Board and I would like to congratulate chapter member, Lance Mervine, who recently passed the CHFP exam. Lance had participated in the joint study group with the NY chapters that we had in the Fall.

Speaking of the joint study group with NY – two bits of good news. First, the NJ chapter won a multi-chapter Yerger award for the Certification study group. Second, the NY chapters plan to do a study session this Fall (based on the new exam material) and our chapter will be participating. Stay tuned. I’ll be getting details out as soon as possible.

I know there have been many questions concerning the new exam and study guide from National. Much of this was addressed in the webinar we held a few months ago. But if you have any questions, please let me know. I believe there will be another informational webinar held by the NY chapters coming up.

Have a great summer.

Rita Romeu, Ph.D., FHFMA
Romeur@comcast.net.
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Equipment Financing and Bond Financing

How Healthcare Organizations are Making the Best Use of Each Financial Product

By Jennifer Vanegas

Today’s healthcare finance professionals have their work cut out for them. The combination of declining reimbursements, cost-cutting measures, and legislative uncertainty has created a complex maze for finance leaders. Most spend an increasing amount of time looking for new ways to bend the cost curve. By evaluating the different financial product options available for capital projects, you can determine the best fit for your needs and generate significant savings for your organization.

**Bond Financing**

Hospitals and other healthcare organizations across the country have looked to debt markets as an attractive source of long-term, fixed-rate financing. However, there are several downsides to issuing bonds. First, they come with material issuance costs and can be administratively burdensome. Time is also a limitation, as it can take anywhere from three months to two years depending on the amount and structure.

Bond financing is generally not a good source for short-term projects or equipment that may have a useful life less than seven years. Putting short-term assets on long-term debt is akin to rolling your groceries into your mortgage. Issuing long-term debt to finance short-lived assets is a costly strategy, even at low rates.

Consider the example in Figure 1, comparing a 20-year bond for $5 million with a fixed interest rate of 3% to a 5-year equipment financing agreement for the same amount with a rate of 4%. The interest costs on the 20-year bond total more than $1.6 million. Despite the equipment financing agreement’s higher rate, its total interest cost is less than a third of the total interest cost for the bond.

Another significant negative issue with debt is the restrictive covenants and blanket liens that limit future flexibility. The uncertainty surrounding healthcare reform in the Patient Protection and Affordable Care Act stands to be the biggest risk if an organization is not able to be nimble and adapt to changes.

**Equipment Leasing & Financing**

Like bond financing, the low-rate environment has fueled equipment leasing and finance products. Healthcare finance professionals have strategically used this source of capital to help prepare for the uncertainty that lies ahead.

Lease financing products are intended for specific equipment or projects that have a useful life of seven years or less, as shown in Figure 2. Organizations are able to take advantage of the low, fixed rates without the issuance burdens or costs typical of bond debt. The lead-time is measured in days, not months or years.

The shorter terms allow organizations to strategically fund projects and equipment with a financial product that is closely aligned with the useful life and with the same low—if not lower—all-in rates as the bond market.

Since leases are collateralized by the equipment being financed, these products do not come with blanket liens or

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*continued on page 32*
debt covenants that restrict an organization’s flexibility. Each project can be evaluated independently for appropriate term & structure. These products also provide organizations with the option to use off-balance sheet financing. This can help increase efficiency metrics such as ROA, but more importantly, navigate around existing covenants the organization might have due to prior debt issuances.

For a more in-depth comparison between the features of equipment financing through First American and bonds, reference Table 1.

Utilizing lease financing as part of a hospital’s capital structure can be a strategic, cost-effective and timely source of capital, especially for short-term assets like IT and medical equipment, furniture, office equipment and buildout costs. Healthcare organizations seeking flexibility and stability in the coming years should look to these products as a complement to their existing capital structures.

About the Author
Jennifer Vanegas is Assistant Vice President with First American Healthcare Finance. She can be reached by email at Jennifer.Vanegas@fahf.com.

### Equipment Financing vs. Bond Financing

<table>
<thead>
<tr>
<th></th>
<th>Leasing or Financing through First American</th>
<th>Bond Financing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Typical Term</strong></td>
<td>2-7 years</td>
<td>10-30 years</td>
</tr>
<tr>
<td><strong>Amount</strong></td>
<td>$100,000 to $20,000,000</td>
<td>$5,000,000 to $200,000,000</td>
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<tr>
<td><strong>Lease Rate</strong></td>
<td>≤0%</td>
<td>Not applicable</td>
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<tr>
<td><strong>Financing Rate</strong></td>
<td>2%-5%</td>
<td>1%-4%</td>
</tr>
<tr>
<td><strong>Fees and Issuance Costs</strong></td>
<td>None</td>
<td>2%-5% of bond amount</td>
</tr>
<tr>
<td><strong>Typical Assets Financed</strong></td>
<td>Short useful life equipment like diagnostics, technology &amp; office equipment and vehicles</td>
<td>Buildings, real estate, construction and expansions</td>
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<tr>
<td><strong>Collateral</strong></td>
<td>Only assets under lease</td>
<td>Letter of credit, insurance, real estate</td>
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<tr>
<td><strong>Liens</strong></td>
<td>Lien solely on leased assets</td>
<td>Blanket lien</td>
</tr>
<tr>
<td><strong>Covenants</strong></td>
<td>None</td>
<td>Common, including debt limitations</td>
</tr>
<tr>
<td><strong>Required Documentation</strong></td>
<td><strong>Minimal</strong>:</td>
<td><strong>Extensive</strong>:</td>
</tr>
<tr>
<td></td>
<td>• 4-page Master Lease plus Equipment Schedule, Delivery Order, and Purchase Option</td>
<td>• Offering documents such as official statement and bond purchase agreement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Legal documents such as loan agreement, mortgages or deeds, tax regulatory agreement, Form 8038</td>
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<tr>
<td></td>
<td></td>
<td>• Resolutions and certificates of the parties</td>
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<tr>
<td></td>
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<td>• Legal opinions</td>
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<tr>
<td></td>
<td></td>
<td>• Other miscellaneous forms such as rating letters and appraisals</td>
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<tr>
<td><strong>Timing for Approval and Funding</strong></td>
<td>2-10 days</td>
<td>≥90+ days</td>
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<tr>
<td><strong>Accounting Treatment</strong></td>
<td>On- or off-balance sheet</td>
<td>On-balance sheet</td>
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</tbody>
</table>

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**Figure 2**

Matching Useful Life with Financial Product

<table>
<thead>
<tr>
<th>Useful Life in Years</th>
<th>Equipment Financing</th>
<th>Bond Financing</th>
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</thead>
<tbody>
<tr>
<td>0</td>
<td>Mobile Devices</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>IT Equipment &amp; Software</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Data Storage &amp; Networking Equipment</td>
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<tr>
<td>30</td>
<td>Medical Equipment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Revenue Generating Equipment</td>
<td>Buildings</td>
</tr>
</tbody>
</table>

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In cooperation with the Metropolitan Philadelphia Chapter

39th Annual Institute of New Jersey Chapter of HFMA
The Borgata Casino & Spa
Wednesday, October 7, 2015 through Friday, October 9, 2015

Registration is now open!
Go to http://www.njhfmainstitute.org/registration/

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In addition to the above, Customized Sponsorship Levels can be crafted to meet any organization's needs. We are happy to work with you to meet your goals!

Our Key Note Speaker is Todd Hunt
“Communication Bleeps and Blunders in Business”
Check him out at: http://www.toddhuntspeaker.com
The committee is hard at work planning for the 39th Annual Institute, which will be held on October 7 through 9 at the Borgata in Atlantic City. Sure hope you can all join us!
The Annual Institute Committee would like to offer a special thanks to Steve Aaron and HBCS for the pictures from the 38th Annual Institute.
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Venue</th>
<th>Speaker/Session Leader</th>
<th>Topic</th>
<th>Category</th>
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<tbody>
<tr>
<td>9:15 - 9:30</td>
<td>Welcome</td>
<td>Ballroom</td>
<td>Jennifer Vanegas</td>
<td>Annual Institute Chair</td>
<td>General</td>
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<tr>
<td>9:30 - 10:20</td>
<td>Opening Session</td>
<td>Ballroom</td>
<td>Christopher Valerian, DO</td>
<td>QualCare, Inc.</td>
<td>General</td>
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<td>10:20 - 11:50</td>
<td>General Session #1</td>
<td>Ballroom</td>
<td>Lyman Sorenberger</td>
<td>Capio Partners</td>
<td>Healthcare Jeopardy</td>
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<tr>
<td>11:50 - 1:15</td>
<td>Lunch &amp; Vendor Fair</td>
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<td>Vendor Hall</td>
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<tr>
<td>12:00 - 12:30</td>
<td>Vendor Demo 1</td>
<td>VD 1</td>
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<td>Avadyna Health</td>
<td>Vendor Demo</td>
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<td>12:00 - 12:30</td>
<td>Vendor Demo 2</td>
<td>VD 2</td>
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<td>ClinicSpectrum</td>
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<td>12:40 - 1:10</td>
<td>Vendor Demo 3</td>
<td>VD 1</td>
<td></td>
<td>PatientKeeper</td>
<td>Vendor Demo</td>
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<td>12:40 - 1:10</td>
<td>Vendor Demo 4</td>
<td>VD 2</td>
<td></td>
<td>Buck Consultants, A Xerox Company</td>
<td>Vendor Demo</td>
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<tr>
<td>1:15 - 2:05</td>
<td>General Session #2</td>
<td>Ballroom</td>
<td>Neil M. Pressman, David A. Gregory</td>
<td>Baker Tilly Virchow Krause, LLP, Baker Tilly Virchow Krause, LLP</td>
<td>General</td>
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<tr>
<td>2:05 - 2:10</td>
<td>Break</td>
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<tr>
<td>2:10 - 3:00</td>
<td>Breakout #1</td>
<td>Studio 1</td>
<td>Kendall Schnurpel, Justin Lowe</td>
<td>EY</td>
<td>Financial Management</td>
</tr>
<tr>
<td>2:10 - 3:00</td>
<td>Breakout #1</td>
<td>Studio 2</td>
<td>Sloan Clardy, Joey Moss</td>
<td>Parallon</td>
<td>Revenue Integrity</td>
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<td>2:10 - 3:00</td>
<td>Breakout #1</td>
<td>Studio 3</td>
<td>David Reitzel</td>
<td>Grant Thornton LLP</td>
<td>Compliance</td>
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<tr>
<td>2:10 - 3:00</td>
<td>Breakout #1</td>
<td>Studio 4</td>
<td>Deborah E Shapiro, Cheryl Lawson</td>
<td>WFS Services, Inc., WFS Services, Inc.</td>
<td>Patient Financial Services</td>
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<td>2:10 - 3:00</td>
<td>Breakout #1</td>
<td>Boardroom 1</td>
<td>Bret S. Bissey</td>
<td>MediTract</td>
<td>Compliance</td>
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<td>2:10 - 3:00</td>
<td>Breakout #1</td>
<td>Boardroom 2</td>
<td>Craig Standen, Chris Seidl</td>
<td>SEI Investments</td>
<td>Compliance</td>
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<td>2:10 - 3:00</td>
<td>Breakout #1</td>
<td>Boardroom 3</td>
<td>Maria Facciponti, Allison Case</td>
<td>Adreima</td>
<td>Patient Financial Services</td>
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<tr>
<td>2:10 - 3:00</td>
<td>Breakout #1</td>
<td>Boardroom 4</td>
<td>Chris Strade, Rita Romeo, HFMA, CHC</td>
<td>Olean Medical Group ZirMed</td>
<td>Revenue Integrity</td>
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<td>2:10 - 3:00</td>
<td>Breakout #1</td>
<td>Boardroom 5</td>
<td>Gerry Blass, Rita Romeu</td>
<td>ComplyAssistant</td>
<td>Compliance</td>
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<tr>
<td>2:10 - 3:00</td>
<td>Breakout #1</td>
<td>Boardroom 6</td>
<td>Perry Mandarino, Kenneth A. Rosen, Esq</td>
<td>PwC Lowenstein Sandler PC</td>
<td>Financial Management</td>
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<tr>
<td>3:00 - 3:10</td>
<td>Break</td>
<td></td>
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<td>KPMG Rutgers, The State University of New Jersey Deloitte MediTract</td>
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<td>Olakunle Olanayan, MD</td>
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<td>5:30 - 8:00</td>
<td>Charity Event</td>
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### Thursday, October 8, 2015

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<tr>
<td>9:00 - 9:50</td>
<td>General Session #1</td>
<td>Ballroom</td>
<td>General</td>
<td>Carol Friesen (HFMA National)</td>
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<td>9:50 - 10:10</td>
<td>Awards</td>
<td>Ballroom</td>
<td>HFMA NJ</td>
<td>Heather Weber (Annual Chapter Awards Ceremony)</td>
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<td>10:10 - 11:00</td>
<td>General Session #2</td>
<td>Ballroom</td>
<td>AR Systems, Inc.</td>
<td>Day Egusquiza</td>
<td>ICD 10 changes everything in the revenue cycle – think beyond HIM</td>
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<td>11:00 - 12:00</td>
<td>Keynote Speaker</td>
<td>Ballroom</td>
<td>Hunt Company</td>
<td>Todd Hunt</td>
<td>Communications Bleeps and Blunders in Business</td>
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<td>12:00 - 1:30</td>
<td>Lunch &amp; Vendor Fair</td>
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<tr>
<td>12:10 - 1:00</td>
<td>Lunch &amp; Learn</td>
<td>Studio 1</td>
<td>HFMA NJ</td>
<td>Rhonda Maroziti (WithumSmith+Brown, PC)</td>
<td>Social Media Trends and Practical Applications for Career Development</td>
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<td>12:10 - 1:00</td>
<td>Lunch &amp; Learn</td>
<td>Studio 2</td>
<td>KPMG</td>
<td>Dion Sheidy, Catherine DiLeary, Jennifer Shimek</td>
<td>Quality of Care: Where do we start?</td>
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<td>1:30 - 2:20</td>
<td>General Session #3</td>
<td>Ballroom</td>
<td>EisnerAmper LLP</td>
<td>Michael McLafferty</td>
<td>2016 Regulatory Review</td>
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<td>2:20 - 3:30</td>
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<td>2:30 - 3:20</td>
<td>Breakout #1</td>
<td>Studio 1</td>
<td>The Halley Consulting Group</td>
<td>Marc Halley (The Halley Consulting Group)</td>
<td>Moving Up the Integration Pyramid</td>
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<td>2:30 - 3:20</td>
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<td>Studio 2</td>
<td>BESLER Consulting</td>
<td>Kathy Ruggieri, Mary Devine, Olga Barone-Alan (BESLER Consulting)</td>
<td>The benefits using data analytics to improve Revenue Cycle and Compliance collaboration</td>
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<td>Breakout #1</td>
<td>Studio 3</td>
<td>Sutherland Healthcare Solutions</td>
<td>Nilo Chakrabarty (Sutherland Healthcare Solutions)</td>
<td>A Framework for Analytics Driven Transformation to Value Based Care</td>
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<td>Studio 4</td>
<td>University of Pennsylvania Health System</td>
<td>Steven Honeywell, Jeff Hinkle, Fred Bloesch, Brendan Borst (University of Pennsylvania Health System)</td>
<td>Improving the Patient Experience-The Impact of Consolidated Patient Billing</td>
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<td>Boardroom 1</td>
<td>Rutgers, The State University of NJ</td>
<td>Deborah L. Carlino (Rutgers, The State University of NJ)</td>
<td>We’re Acquiring a Physician Practice, What Do We Do Now?</td>
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<td>PFM</td>
<td>Christine Doyle, Bob Guadagnio (PFM PFM)</td>
<td>Direct Bank Placements</td>
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<td>Studio 3</td>
<td>ClinicSpectrum, Inc.</td>
<td>Vishal Gandhi (ClinicSpectrum, Inc.)</td>
<td>Ideal Practice Workflow for Revenue Maximization and Cost Efficiency</td>
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<td>DGA Partners</td>
<td>Idette Elizondo, Meghan Corcoran (DGA Partners)</td>
<td>Population Health – Key Ingredients to Success</td>
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<td>Recondo Technology</td>
<td>Elizabeth R. Staas (Recondo Technology)</td>
<td>Transforming Revenue Cycle from Administrative to Patient Service - Engaging Touch Free Practices</td>
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<td>Studio 1</td>
<td>Panacea Healthcare Solutions, Inc.</td>
<td>Kim Charland, Greg Adams (Panacea Healthcare Solutions, Inc.)</td>
<td>What Value Are We Gaining from Value-Based Purchasing?</td>
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<td>4:30 - 5:20</td>
<td>Breakout #3</td>
<td>Studio 2</td>
<td>BESLER Consulting</td>
<td>Maria C. Miranda, FACHE Robert Mahoney, Scott Besler (BESLER Consulting)</td>
<td>The Uncertain Future of Medicare Passthrough and Add-ons</td>
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<td>Breakout #3</td>
<td>Studio 3</td>
<td>CarePayment</td>
<td>Dan Kutchel (CarePayment)</td>
<td>Patient-Friendly Billing: How Retailization is Shaping Revenue Cycle Strategy</td>
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<td>Studio 4</td>
<td>MedAptus, Inc.</td>
<td>Ryan Secan, MD (MedAptus, Inc.)</td>
<td>Shorten the Revenue Cycle with ICD-10</td>
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<td>Boardroom 1</td>
<td>Strategic System Solutions, LLC</td>
<td>Cynthia Korman (Strategic System Solutions, LLC)</td>
<td>It Can Grow On Trees: Winning Strategies for Value-Based Purchasing</td>
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<td>Cammach Health LLC</td>
<td>Erin O’Connor, Beth Barker (Cammach Health LLC)</td>
<td>Using Your Employee Benefit Plan to Advance Your Value-Based Care Strategy and Reduce Hospital Expenses: the Southwest Health Plan Experience</td>
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<td>6:00 - 8:00</td>
<td>President’s Reception</td>
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<td>Late Night Get Together</td>
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### Friday, October 9, 2015

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<td>Jack Hoban (RGI Leadership Under Stress)</td>
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<td>Convergent Revenue Cycle Mgmt., Inc.</td>
<td>Patricia Kloechn, James Hawkins (Convergent Revenue Cycle Mgmt., Inc.)</td>
<td>Creating a Concierge Patient Experience</td>
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<tr>
<td>Spring Issue—March/April/May</td>
<td>March 1</td>
<td>Data &amp; Health Information Management; Data Security; Solar Energy</td>
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<tr>
<td>Summer Issue—June/July/August</td>
<td>June 1</td>
<td>Telemedicine; Next Generation ACOs; NY’s Emergency Medical Services and Surprise Bills</td>
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<td>Fall Issue—September/Sept</td>
<td>August 15</td>
<td><em>Special ANNUAL INSTITUTE Issue</em></td>
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<td>Fall Issue—October/Nov</td>
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<td>Bonus Distribution at HFMA-NJ’s 39th Annual Institute in Atlantic City, October 7-9, 2015!</td>
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<tr>
<td>Fall Issue—November</td>
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<td>Topics: Spotlighting issues and topics shared by the Institute presenters.</td>
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<tr>
<td>Winter Issue—December</td>
<td>December 1</td>
<td>TBD, in order to report on the most relevant issues in healthcare at that time.</td>
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Is your hospital one of the 2,610* receiving reduced Medicare payments in 2015 due to excess readmissions?

*Source: Kaiser Health News

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