The New Jersey HFMA Chapter celebrates its diamond jubilee anniversary!
WithumSmith+Brown understands the challenges facing healthcare professionals today and offers a wealth of resources and expertise to put your facility in a position of strength.

**HEALTHCARE SERVICES GROUP**
Scott J. Mariani, JD, Practice Leader • 732.341.8728
Dan Vitale, CPA, Practice Leader • 973.898.9494
Healthcare@withum.com

QUALITY SERVICE AND EXTRAORDINARY INSIGHT ARE PART OF OUR DNA

**withum.com**

WithumSmith+Brown, PC
AUDIT • TAX • ADVISORY
39th Annual Institute Draws Over 500 Registrants
by John J. Dalton, FHFMA .............................................................. 8

The NJ HFMA Chapter Salutes our Past President's at our 60th Anniversary Celebration!
by John Shire .................................................................................. 12

Legal Structural Compliance Developments for ACOs under the Medicare Shared Savings Program (MSSP)
by John Shire .................................................................................. 15

2016 New Year's Resolutions for CFOs
by Lew Bivona, CPA, AFE ................................................................. 19

What's On Your Nightstand?
NJ HFMA Members Share Their Favorite Reads .................................. 24

A Different Model of Care
by Scott Millard ................................................................................ 25

The Costs of Medical Privacy Breach
by John Zen Jackson, Esq. ................................................................. 28

Forty Year Retrospective
by Frank Ciesla ................................................................................ 33

Building an Integrated Population Health Data (iPHD) Project for New Jersey
by Natassia M. Rozario ..................................................................... 36

The ROI for Using Integrative Health Modalities as an Adjunct to Conventional Care: A Case Study
by Ruthann Russo, PhD, JD, MPH, Lac ............................................. 42

Who’s Who in the Chapter ...... 2
The President’s View
by Heather Weber ................................................................. 3
New Members ................................................................. 11
Who’s Who in NJ
Chapter Committees ................................................................. 21
Focus on Finance ................................................................. 22
Mark Your Calendar ................................................................. 24
Job Bank Summary ................................................................. 32
Advertising Policy/Annual Rates

The Garden State “FOCUS” reaches over 1,000 healthcare professionals in various fields. If you have a product or service you would like the healthcare financial industry to know about, please take advantage of this great opportunity!

Contact Laura Hess at 888-652-4362 to place your ad or receive a copy of the Chapter’s advertising policy. The Publications Committee reserves the right to refuse any ad not consistent with the overall mission of the Chapter. Inclusion of an ad in this Newsmagazine does not infer endorsement of the product or service by the Healthcare Financial Management Association or the Publications Committee. Neither the Healthcare Financial Management Association nor the Publications Committee shall be responsible for slight variations in production quality of published advertisements. Effective July 2015 Rates for 4 quarterly issues are as follows:

<table>
<thead>
<tr>
<th>Color</th>
<th>Per issue/Total</th>
<th>Per issue/Total</th>
<th>Per issue/Total</th>
<th>Per issue/Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1x</td>
<td>2x (10% off)</td>
<td>3x (15% off)</td>
<td>Full Run (20% off)</td>
</tr>
<tr>
<td>Black &amp; White</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full Page</td>
<td>$675</td>
<td>$607 / $1,214</td>
<td>$573 / $1,719</td>
<td>$540 / $2,160</td>
</tr>
<tr>
<td>Half Page</td>
<td>$450</td>
<td>$405 / $810</td>
<td>$382 / $1,146</td>
<td>$360 / $1,440</td>
</tr>
<tr>
<td>Quarter Page</td>
<td>$275</td>
<td>$247 / $494</td>
<td>$233 / $699</td>
<td>$220 / $880</td>
</tr>
<tr>
<td>Color</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back Cover – Full Page</td>
<td>$1,450</td>
<td>$1,305 / $2,610</td>
<td>$1,232 / $3,696</td>
<td>$1,160 / $4,640</td>
</tr>
<tr>
<td>Inside Front Cover – Full Page</td>
<td>$1,350</td>
<td>$1,215 / $2,430</td>
<td>$1,147 / $3,441</td>
<td>$1,080 / $4,320</td>
</tr>
<tr>
<td>Inside Back Cover – Full Page</td>
<td>$1,350</td>
<td>$1,215 / $2,430</td>
<td>$1,147 / $3,441</td>
<td>$1,080 / $4,320</td>
</tr>
<tr>
<td>First Inside Ad – Full Page</td>
<td>$1,300</td>
<td>$1,170 / $2,340</td>
<td>$1,105 / $3,315</td>
<td>$1,040 / $4,160</td>
</tr>
<tr>
<td>Full Page</td>
<td>$1,100</td>
<td>$990 / $1,980</td>
<td>$935 / $2,805</td>
<td>$880 / $3,520</td>
</tr>
<tr>
<td>Half Page</td>
<td>$800</td>
<td>$720 / $1,440</td>
<td>$680 / $2,040</td>
<td>$640 / $2,560</td>
</tr>
</tbody>
</table>

Ads should be submitted as print ready (CMYK) PDF files along with hard copy. Payment must accompany the ad. Deadline dates are published for the Newsmagazine. Checks must be payable to the New Jersey Chapter - Healthcare Financial Management Association.

DEADLINE FOR SUBMISSION OF MATERIAL

<table>
<thead>
<tr>
<th>Issue</th>
<th>Date</th>
<th>Submission Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall</td>
<td>August 15</td>
<td></td>
</tr>
<tr>
<td>Winter</td>
<td>November 1</td>
<td></td>
</tr>
<tr>
<td>Spring</td>
<td>February 1</td>
<td></td>
</tr>
<tr>
<td>Summer</td>
<td>June 1</td>
<td></td>
</tr>
</tbody>
</table>

IDENTIFICATION STATEMENT

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

Periodical postage paid at Trenton, NJ 08690. POSTMASTER: Send address change to Garden State “FOCUS” c/o Laura A. Hess, HFMA, Chapter Administrator, Healthcare Financial Management Association, NJ Chapter, P.O. Box 6422, Bridgewater, NJ 08807

OBJECTIVE

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

EDITORIAL POLICY

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

The Communications Committee reserves the right to accept or reject contributions and Communications Committee assume no responsibility for the accuracy or content of any articles or features published in the Newsmagazine.

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

REPRINT POLICY

The New Jersey Chapter of the HFMA will not reprint articles published in Garden State FOCUS Newsmagazine. Individuals wishing to obtain reprint authorization must obtain it directly from the author(s) of the article. The cover of the FOCUS may not be used in the reprint; however, the reprint may note that the article was published in a specific issue. The reprint may not imply endorsement by the HFMA, directly or indirectly.
Hello everyone,

As the President of the HFMA New Jersey Chapter for the 2015-2016 Chapter year, I wanted to welcome everyone to the Winter Edition of the Garden State Focus. I cannot believe that I am halfway through my term as president. Time is going quickly, but it has been an exciting few months.

The 39th Annual New Jersey Institute was held on October 7th, 8th, and 9th at the Borgata in Atlantic City. We had 538 attendees this year that participated in the event. I want to personally thank Jennifer Vanegas, Michael McKeever, and all the members of Institute and education committees that worked tirelessly to put on such an exceptional event. I am overwhelmed by the dedication and commitment to the chapter and to the Institute that these individuals exhibit. I also want to thank all our Institute sponsors whose continued support makes it possible year after year to provide the education sessions and networking opportunities at the Annual Institute and throughout the entire year. Lastly, I would like to thank John Dalton for being our master of ceremony for the Institute this year and for writing the summary article included in this Focus addition. After reading that, there is not more I need to say.

On November 12, 2015, we held a 60th Anniversary Event which honored our past presidents, celebrating their service and dedication which has made the NJ Chapter what it is today. There were 12 past presidents that were in attendance, and once again, we thank you for all you have done for our Chapter. It was a great event and I want to thank Maria Facciponti, the chair, and Peter Demos and Brittany Pickell the co-chairs of the Membership Services/Networking committee, and the entire committee for working hard to put on this event. It was a lot of fun. There is a lot for this chapter to be proud of, and since 1999 our chapter has received 72 awards from National.

As I look forward to the next half of my term, I am even more committed to continuing the nationally recognized educational programming to our members. We are working on additional networking events as well. 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, the pictures of our recent events, and they inspire you to become more involved in our events. 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. It is not too late. There is no cost to participate, no advance sign-up or registration required, and the opportunity to learn and network. If you have any questions or ideas, please do not hesitate to reach out to me or any of the New Jersey HFMA leadership.

Lastly, I want to wish our membership a happy and safe holiday season. No matter what holiday you are celebrating, I hope you have time to spend it with family and friends. I’m looking forward to seeing everyone in the New Year.

Heather L. Weber
The Communications Committee would like to wish our fellow NJHFMA members a wonderful holiday season.

Brian Herdman, Elizabeth Litten, Al Rottkamp, Mark Dougherty, Joe Fallon, Laura Hess, John Manzi, Rhonda Maraziti, Nicole Martin, Bill McCann, David Mills, Amina Razanica, and Jim Robertson.
ARMC has collected over $30 million in written-off denials.

That money would have been lost forever, but ended up going directly to our clients’ bottomline.

Just sayin’...
39th Annual Institute Draws Over 500 Registrants

by John J. Dalton, FHFMA

Photography by Steve Aaron, HBCS

The opportunity to garner up to 17 CPEs on a broad range of topics once again drew more than 500 registrants to Atlantic City’s Borgata Hotel for the 39th Annual Institute cosponsored by the Metropolitan Philadelphia and New Jersey HFMA Chapters. Institute Committee Chair Jennifer Vanegas opened Wednesday morning by welcoming attendees and thanking the numerous sponsors without whose support so cost-effective an educational institute would not be possible. She then introduced Dr. Christopher Valerian, Kevin Joyce, Fred Morelli and John Dellocono presenting “Direct to Market: Bringing Value to the Community,” a case study illustrating CentraState Health System’s partnership with Cigna/QANI to deliver a value-based health plan to the market. Next, Lyman Sornberger, Chief Strategy Officer at Capio Partners discussed Exchanges, 501(r), the Inpatient Prospective Payment System and ICD-10 as prelude to a hotly contested round of “Healthcare Jeopardy.” Six teams competed vigorously to demonstrate their knowledge of the topics. Ably captained by Chapter President Heather Weber, Team Dobosh (Amy Ciuffreda, John Dalton, Gail Kosyla and Rick Parker), won by the narrowest of margins.

The lunch period included four vendor demonstrations in the Vendor Hall. Master of Ceremonies John Dalton opened the afternoon session, thanking Heather Weber, Jennifer Vanegas and Mike McKeever for producing an excellent educational Institute, then introduced Neil Pressman, Principal at Baker Tilly, who discussed “Physician Employment: Optimal Integration.” He illuminated a broad range of hospital-physician employment models including IPAs, PHOs, MSOs, ACOs, integrated delivery systems and others, illustrating that one size does not fit all. The remainder of the afternoon offered a series of three one-hour breakout sessions on six different topics each hour, including compliance, managed care contracting, revenue integrity, patient financial services, financial management and reimbursement.

Thursday – Keynote Address: Go Beyond…

Carol A. Friesen, FHFMA, Secretary/Treasurer of HFMA’s National Board of Directors, challenged attendees to “Go Beyond” their limits to succeed in the challenging and rapidly changing marketplace as value-based payment replaces fee-for-service. Ms. Friesen is Vice President of Health System Services at Bryan Health in Lincoln, Nebraska and provided some fascinating insights into rural healthcare delivery for her colleagues in the country’s most densely populated state. She then illustrated how Medicare’s goal of having 50 percent of FFS payments through alternative payment models by 2018 is bending the cost curve, and urged attendees to go beyond current models of collaboration, citing the formation of Vivity in Southern California as just one example.

Bringing quality measures into the equation, Ms. Friesen noted the need to go beyond the raw numbers in engaging consumers on quality, patient safety and pricing. Quoting Albert Einstein “Once we accept our limits, we can begin to go beyond them,” she concluded that finance professionals can no longer cruise in a comfort zone, but must go beyond it as the market moves from volume to value.

Chapter Awards Ceremony

Next, Chapter President Heather Weber presented the annual Chapter Awards. Recipients included:

• President’s Award: Jennifer Vanegas, Institute Chair;
• Leading the Change Award: Heather Stancisi, Chair, Women’s Event;
• Sister Mary Gerald Bronze Awards of Excellence for Education: Michael McKeever, Stacey Bigos, Mary Cronin;
• C. Henry Hottum Awards for Educational Performance Improvement: Michael McKeever, Stacey Bigos, Mary Cronin;
• Award of Excellence for Improved Chapter Performance: Tracy Davison-DiCanto, Chapter President;
• YERGER Award for an all-day education program: Stacey Bigos, Lisa Hartman, Jennifer Shimek, Deb Carlino, Tony Panico and Dara Quinn
• YERGER Award for Collaboration with New Jersey Healthcare Information and Management Systems Society: Michael McKeever, Stacey Bigos, Mary Cronin;
• YERGER Award for Region 2 and Region 3 Collaboration Certification Study Group 2: Rita Romeu;
• YERGER Award for Annual Institute Make-A-Wish Charity Event: Tracy Davison-DiCanto, Jennifer Vanegas, Michael McKeever;
• YERGER Award for Annual Institute Financial Improvement: Tracy Davison-DiCanto, Jennifer Vanegas, Michael McKeever;
• Medal of Honor: Tracy Davison-DiCanto, John Brault, Maria Facciponti;
• Muncie Gold Award: Scott Mariani;
• Reeves Silver Award: Stacey Bigos, CHFP;
• Follmer Bronze Award: Deborah L. Carlino, Brian S. Herdman, Kevin Joyce, Angela M Melillo, Sean D. O’Rourke, Jennifer A Vanegas.

Day Egusquiza - ICD-10’s increased specificity enables providers to better assign costs to procedures performed.

ICD-10 Changes Everything
In a reprise of her 2013 performance, Day Egusquiza, President, AR Systems, Inc. gave illuminating insights into how ICD-10 is changing everything in the revenue cycle. Like Carol Friesen, Day hails from a rural state – Idaho – where 37 of the 47 hospitals are less than 25 beds. A nationally recognized speaker on continuous quality improvement (CQI), her presentation resounded with common sense.

While the rest of the developed world moved to ICD-10 from 1995-2001, the United States is late to the game. Day pointed out that ICD-10’s increased specificity enables providers to better assign costs to procedures performed. For example, ICD-9 has a code for laceration of an artery; ICD-10 lets you know whether that artery was in a finger or in a heart. Similarly, ICD-9 has only one code for a noncompliant patient (personal history of noncompliance with medical treatment); ICD-10 has five, including noncompliance with dietary regimen, intentional under dosing of medication regimen due to financial hardship and unintentional under dosing of medication due to age-related disability.

A big fan of brown bag lunch and learns, Day sees hospitals as outsourcing agents to help small physician practices with their coding. To those who complain that ICD-10 is too complicated, she responds “It’s the patient’s story.”

Communications Bleeps and Blunders
On a lighter note, communications expert and humorist Todd Hunt delivered several hilarious examples of miscommunications. Born in Chicago, Todd was raised in rural Rockville City, Iowa (population 2,316). Combining several examples of poor communications with a quirky delivery style, Hunt humorously reinforced his basic tenet: “Communicate not just so clearly that we’re understood, but so precisely that we cannot possibly be MISunderstood.”

Todd Hunt - Communicate not just so clearly that we’re understood, but so precisely that we cannot possibly be MISunderstood.

2016 Regulatory Review
Following a break for lunch and learns and vendor demonstrations, Mike McLafferty, partner at EisnerAmper, provided an extensive and detailed regulatory update. New developments include CMS’s Hip/Knee bundled payment care initiative (BPCI) and New Jersey Medicaid’s three year ACO demonstration project. More than 2,000 providers will be assuming risk under the BPCI.

continued on page 8
He expressed concern about HHS’s proposed new limits on the 340B drug program and the projected 23 percent increase in specialty pharmacy costs. The latest 340B guidance increases provider’s administrative burden.

On the compliance front, Mike provided several examples of recent major judgments and settlements. Perhaps the most alarming development is the recent Department of Justice memorandum stating that there will be no more corporate fraud settlements without “culpable” individuals.

Paralleling Wednesday’s format, the remainder of the afternoon offered a series of three one-hour breakout sessions on six different topics each hour, including compliance, managed care contracting, revenue integrity, patient financial services, financial management and reimbursement.

**Leadership Under Stress**

New Jersey Chapter member Jack Hoban, owner of ARMC Denial Services, opened the Friday morning session with a fast-paced and thought-provoking demonstration of the relevance of Marine ethics in life and business. A subject matter expert for the U.S. Marine Corps Martial Arts Program, Captain Jack’s data on trust and confidence in business are compelling. A recent Gallup poll on “Confidence in Institutions” placed the military and small businesses at the top, with big business, TV news and Congress at the bottom. Within the military, Marines outranked all other branches by a wide margin.

The ethical leader successfully inspires and directs a group of people to accomplish the mission while protecting the welfare of the people through the use of human understanding and moral character. Ethics are moral values in action. A person who knows the difference between right and wrong – and chooses the right – is moral. A person whose morality is reflected in their willingness to do the right thing – even if it is hard or dangerous – is ethical.

Using Marine Corps leadership traits and principles, Hoban gave several examples from his own experience that reinforced the value of ethical leadership at work and at home.

**Creating a Concierge Patient Experience**

Patricia Kloehn, Consultant, Patient Access Solutions at Convergent, took the audience through an exercise in transforming patient access representatives into patient experience consultants resulting in higher patient satisfaction scores. The patient experience is becoming more public thanks to sites like Yelp and Angie’s List, and Millennials (91 million) are driving change more so than Gen X (61 million) or Baby Boomers (77 million). Savvy providers are moving to mobile apps for appointments, reminder, instructions, directions and the like.

By enabling a great “front door” patient experience, access management facilitates a positive start to the revenue cycle and utilizes resources accurately and optimally. Satisfied patients pay their bills.

**Patrick Kloehn - Satisfied patients pay their bills.**

**Panel Discussion**

Chapter President Heather Weber, Partner at Baker Tilly, moderated a panel discussion on current issues facing the healthcare industry in our region. Panelists included Tom

---

continued from page 7
Baldosaro, Executive Vice President and CFO, Inspira Health, Gail Kosyla, CFO and Senior Vice President, Strategy, Hunterdon Healthcare System, Frank Pipas, Vice President of Finance, Hackensack University Medical Center, and Russell Wagner, Senior Vice President of Finance, Holy Redeemer Health System.

Panelists gave their opinions on a broad range or regulatory changes, physician issues, exposure to risk and payer issues. Concerns were expressed about the potential negative effects of the recent court ruling in the Morristown property tax case, and Horizon Blue Cross’s recent announcement of its OMNIA Health Alliance. Panelists generally agreed that New Jersey’s hospitals are not prepared to take on risk contracts, and that physician alignment is a task that needs to be focused on each and every day.

Cyber attacks and cyber security are a significant concern. Panelists discussed using “ethical” hackers to assess vulnerability, noting that cyber insurance is quite expensive. All agreed that the “two midnight” rule is confusing to patients and staff. The discussion will be continued at the 40th Annual Institute October 5-7, 2016.

Not All Work – Some Play
Sponsored by First American Healthcare Finance, Wednesday evening’s Casino Night and Gift Auction raised money for the Make-A-Wish Foundation as attendees played various table games competing for prizes. Thursday Evening’s President’s Reception was held alongside the Borgata Pool in fine autumn weather, providing attendees with a welcome breather following two days of intense educational sessions. The late night get together at mur.mur found many attendees dancing to 70s and 80s rock music.

About the author
John J. Dalton, FHFMA, is a former Chapter President, National Board member, and HFMA’s 2001 Morgan Award winner for lifetime achievement in healthcare financial management, the only New Jersey Chapter leader to receive that honor. Now retired as Senior Advisor to BESLER Consulting, he remains involved in healthcare as Trustee and Chair of the Strategic Planning Committee at the St. Joseph’s Healthcare System and as Honorary Trustee at Children’s Specialized Hospital where he serves on the Audit & Compliance Committee.
continued from page 9
Update to Out of Network Bill

By: Neil Eicher

The New Jersey Hospital Association is committed to working with legislative leaders and stakeholders on protecting patients from surprise medical bills. NJHA members have been meeting over the summer as a Task Force charged with offering constructive solutions to this legislative discussion. We believe that a patient should not be exposed to an out of network bill when the patient does everything he or she can do to confirm network status with the healthcare providers participating in that patient’s procedure. Disclosure to the patients must be a shared responsibility between healthcare providers and insurers. Whatever the legislative outcome may be, it is important that a healthcare facility or physician does not lose the ability to negotiate fair in-network rates with health insurers.

New Members

Marianne G. Ippolito
Saint Peter’s Healthcare System
Managed Care Coordinator
(732) 249-9572
mippolito@saintpetersuh.com

Joseph A. Polak
Saint Peters University Hospital
Manager, Resource Services
(732) 937-6056
jpolak@saintpetersuh.com

Vipul Ahuja
WNS
Associate VP
(201) 942-6254
vipul.ahuja@wns.com

Kyle Sherseth
(404) 574-6365
Kyles@triageconsulting.com

Christina Oery
Senior Associate
ChristinaOery@gmail.com

Diane Biletta
Meridian Health
Sr. Internal Auditor
(732) 481-8538
dbiletta@meridianhealth.com

Thomas Fogerty
BESLER Consulting
Marketing Manager
(732) 392-8308
tfogerty@besler.com

John C. Miller III
Mattleman, Weinroth & Miller
Attorney
(856) 429-5507
jmiller@mwm-law.com

Heather Ross
(215) 400-0518
heather.ross@dphs.uphs.upenn.edu

Cory Lasker
(201) 821-8764
corylasker@gmail.com

Thomas Onuska
Robert Wood Johnson University Hospital
Financial & Planning Advisor
(570) 280-8590
tonuska@gmail.com

Patricia A. Howard
UnitedHealth Group/Optum360
Senior Vice President
(609) 301-2085
Patricia.Howard@Optum.com

Anna Sidorova
Holy Name Medical Center
Accounting Manager
(201) 833-3318
sidorova@holyname.org

Tracey Pregon
(201) 803-4491
tpregon125@gmail.com

Manny E. Aponte
AtlanticCare
Board Member
(609) 569-7040
manny.aponte@gmail.com

Sheila M. Mints
Esquire
Parker McCay, PA
attorney
(856) 985-4025
smints@parkermccay.com

Jimmy H. Larios-Flores
Assurance Professional
(732) 516-4940
jim.lariosflores@ey.com

Adhish Rajkarnikar
Director of Decision Support and Finance
(856) 783-1016
a.rajkarnikar@kennedyhealth.org

Bryan J. Carey
Sunspire Health
EVP & CFO
(973) 526-6264
bcarey@sunspirehealth.com

Diane Castner
Capital Health
Director Denial Management
(609) 815-7815
dcastner@capitalhealth.org

Todd R. Keller
Commerce Bank
Vice President
(908) 806-3389
todd.keller@commercebank.com

Kyle Kramer
BAYADA Home Health Care
Senior Reimbursement Associate
(856) 793-2414
kkramer@bayada.com

Lisa Giglia
Robert Wood Johnson University Hosp
Audit & Compliance Coordinator
(732) 729-7670
lisa.giglia@rwjuh.edu
### The NJ HFMA Chapter Salutes our Past President’s at our 60th Anniversary Celebration!

<table>
<thead>
<tr>
<th>Past Presidents</th>
<th>Term in Office</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1985-1987</td>
<td></td>
<td>Karen E. Lumpp, CPA</td>
</tr>
<tr>
<td>1983-1985</td>
<td></td>
<td>Richard E. Murray, CPA</td>
</tr>
<tr>
<td>1982-1983</td>
<td></td>
<td>Philip C. Licetti</td>
</tr>
<tr>
<td>1981-1982</td>
<td></td>
<td>Paul Chiafullo</td>
</tr>
<tr>
<td>1980-1981</td>
<td></td>
<td>James T. Monahan, FHFMA</td>
</tr>
<tr>
<td>1979-1980</td>
<td></td>
<td>Mark R. Scott</td>
</tr>
<tr>
<td>1977-1978</td>
<td></td>
<td>Mary Sloboda</td>
</tr>
<tr>
<td>1976-1977</td>
<td></td>
<td>Laurence Samuel</td>
</tr>
<tr>
<td>1975-1976</td>
<td></td>
<td>Gerald D. Neal</td>
</tr>
<tr>
<td>1973-1975</td>
<td></td>
<td>Thomas Dalton</td>
</tr>
<tr>
<td>1972-1973</td>
<td></td>
<td>William K. Hogan</td>
</tr>
<tr>
<td>1971-1972</td>
<td></td>
<td>Finley E. Campbell</td>
</tr>
<tr>
<td>1970-1971</td>
<td></td>
<td>Frank K. Munke</td>
</tr>
<tr>
<td>1968-1969</td>
<td></td>
<td>Thomas Romeo</td>
</tr>
<tr>
<td>1967-1968</td>
<td></td>
<td>John Farmer</td>
</tr>
<tr>
<td>1966-1967</td>
<td></td>
<td>George M. Fried</td>
</tr>
<tr>
<td>1965-1966</td>
<td></td>
<td>Andrew T. Suppa</td>
</tr>
<tr>
<td>1964-1965</td>
<td></td>
<td>Robert Lenharr</td>
</tr>
<tr>
<td>1963-1964</td>
<td></td>
<td>Louis Giammarino, FHFMA, CPA</td>
</tr>
<tr>
<td>1962-1963</td>
<td></td>
<td>A. Bruce Leslie</td>
</tr>
<tr>
<td>1961-1962</td>
<td></td>
<td>Emil I. Horak</td>
</tr>
<tr>
<td>1960-1961</td>
<td></td>
<td>William T. Gill</td>
</tr>
<tr>
<td>1959-1960</td>
<td></td>
<td>Henry Creston</td>
</tr>
<tr>
<td>1958-1959</td>
<td></td>
<td>James F. Hannah</td>
</tr>
<tr>
<td>1957-1958</td>
<td></td>
<td>James B. Moore</td>
</tr>
<tr>
<td>1956-1957</td>
<td></td>
<td>William T. Gill</td>
</tr>
<tr>
<td>1955-1956</td>
<td></td>
<td>Robert M. Shelton</td>
</tr>
</tbody>
</table>
We bring our 43 years of experience from the front lines of health care management to providers facing today’s challenges.

- **Revenue Cycle Enhancement** – Boost financial performance with billing outsource, revenue recovery, and cash acceleration services.
- **Turnaround and Strategic Planning** – Prepare for bundled payment arrangements.
- **Case Management Support** – Prevent denials, improve clinical documentation, and assign patient status correctly the first time.
- **Compliance Audit** – Evaluate key risk areas, including documentation of medical necessity, charge capture, and regulatory compliance.

**Contact us today.**

Jeffrey Silvershein, Principal
800.767.6203
info@McBeeAssociates.com

McBeeAssociates.com | @McBeeAssociates
If you are a hospital or health system that owns and operates an accountable care organization (ACO) participating in the Medicare Shared Savings Program (MSSP), or if you are seeking to participate in the MSSP in the future, then you must be in compliance with a host of state and federal laws and regulations that govern your ACO’s legal existence, governance, and operations. Pursuant to the MSSP, healthcare providers and suppliers that participate in ACO arrangements receive Medicare fee-for-service payments under Parts A and B; however, the ACOs that meet specified quality and savings requirements may be eligible to receive a shared savings payment.

Recent developments in rulemaking under the MSSP necessitate that you now understand the legal structural compliance requirements contained in the final MSSP implementation regulations (Final Rule), which will determine several outcomes for your ACO, including: (i) legal entity selection; (ii) governance composition, operations and duties; and (iii) legal contents of contractual agreements between your ACO and its contract parties. These regulations were promulgated by CMS, pursuant to the Final Rule, on June 4, 2015 (and published in the Federal Register on June 9, 2015). 80 Fed. Reg. 32692 (June 9, 2015)1.

At the state level, your ACO can only exist pursuant to the legal authority pronounced under your state’s law. Specifically, state law will dictate ACO corporate form to ensure compliance with several legal hurdles, including: (i) the corporate practice of medicine doctrine; (ii) licensing and/or certification requirements; (iii) fraud and abuse requirements; (iv) provider referral restrictions; (v) antitrust requirements; (vi) privacy and security law; and (vii) state “Blue Sky” laws.

At the federal level, your ACO must be in compliance with fraud and abuse laws and regulations, including the federal anti-kickback statute, 42 U.S.C. § 1320a-7b(b), the federal physician self-referral prohibition, 42 U.S.C. § 1395nn, and civil monetary penalties law provisions, 42 U.S.C. § 1320a-7a; however, the ACA provided authority to the U.S. Department of Health and Human Services (DHHS) to establish waivers from compliance with the federal fraud and abuse laws as necessary to carry out the mission of the MSSP. In the Fourth Quarter of 2011, the Centers for Medicare & Medicaid Services (CMS) and the DHHS, Office of the Inspector General (OIG) released a joint interim Final Rule, 76 Fed. Reg. 67992 (October 20, 2011) with Comment Period governing the MSSP waiver program; however, these waivers only apply to the federal fraud and abuse laws and do not address existing state laws.

Your ACO must also comply with the federal Health Insurance Portability and Accountability Act of 1996, as amended, and implementing regulations (“HIPAA”). In most instances, the ACO will be a business associate under HIPAA and must enter HIPAA-compliant business associate agreements with participating health care providers. Thus, the ACO must comply with the terms of its Data Use Agreement with CMS, as well as the terms of any business associate agreement it enters with individual providers participating in the ACO.

A detailed discussion of the state laws applicable to ACOs, and the impact of these laws on legal structure, governance and operations will follow in our subsequent ACO Compliance Series for Hospitals and Health Systems. We will also explore the federal law issues applicable to ACOs, including an in-depth look at the fraud and abuse waiver program (and state responses to the waiver program), and a discussion of the tax-exemption compliance issues presented by ACO relationships.

In this issue of ACO Compliance Series for Hospitals and Health Systems, we describe the key legal structural compliance requirements contained in the MSSP Final Rule that will determine the following four outcomes for your ACO

1. Which of your legal entities serves as the operating ACO?

In general, your ACO must be a legal entity, formed under
state, federal or tribal law, which is authorized to conduct 
business in each state in which it operates for the following 
four purposes: (i) receiving and distributing shared savings; 
(ii) repaying shares losses or other monies determined to be 
owned to CMS; (iii) establishing, reporting and ensuring pro-
vider compliance with healthcare quality criteria, including 
quality performance standards; and (iv) fulfilling all ACO 
functions required by 42 C.F.R. § 425.100 et seq. 42 C.F.R. 
§425.104(a).

Pursuant to the Final Rule, if your ACO includes two (or 
more) independent ACO participants, then your ACO must 
be a separately-formed legal entity that is independent from 
any of the ACO participants. Id. at §425(b). What this means 
for you is that if your ACO is comprised of multiple ACO 
participants (and each belongs to the same health system), 
then the ACO legal entity must be a separately formed en-
tity that is distinct from any one of the multiple providers 
and/or suppliers who participate in the ACO. 80 Fed. Reg. 32692, 
32716 (June 9, 2015).

Conversely, the Final Rule adds new text to provide that an 
ACO formed by a single ACO participant may use its exist-
ing legal entity (and governing body) for operations; provided, 
however, that it satisfies all of the general criteria described 
above and the governance criteria discussed below in (Question 
2). 42 C.F.R. §425.104(c).

Existing legal entities (i.e. those entities not specifically 
formed to participate in the MSSP program as an ACO), such 
as independent practice associations (IPAs) or physician-hospi-
tal organizations (PHOs)) that are typically engaged in activi-
ties unrelated to MSSP may only participate in the MSSP as 
ACOs if all of the entities’ members participate in all line of 
business performed by such entities. As discussed below, the 
Final Rule amends previous regulations to impose fiduciary 
duties (i.e. the duty of loyalty) on the members of the govern-
ning body of the ACO. Id. § 425.106(b)(3).

2. What requirements control the composition, operations and 
duties of your ACO’s governing body?

   a. Composition.

   There are five rules controlling the composition of your 
ACO’s governing body. First, your ACO must provide for 
meaningful participation in the composition (and control) of 
your ACO’s governing body for ACO participants or their des-
ignated representatives. 42 C.F.R. §425.106(c). This provision 
reflects CMS’ preference that an ACO be operated by Medi-
care-enrolled entities that directly provide healthcare services 
to beneficiaries, but accommodates smaller groups of provid-
ers that lack the resources necessary to form an ACO and ad-
minister the program requirements on their own. 80 Fed. Reg. 
32692, 32718 (June 9, 2015).

   Second, your ACO governing body must include one or 
more Medicare beneficiary representatives who are served by 
your ACO. Neither the beneficiary representative(s) (nor an 
immediate family member of the representative(s)) can have a 
conflict of interest with your ACO. Third, at least 75 percent 
of the voting control of your ACO’s governing body must be 
held by ACO participants. Fourth, such governing body mem-
ers may serve in a similar manner for a participant of your 
ACO.

   Finally, if the composition of your ACO’s governing body 
does not comply with the beneficiary rule and the 75 percent 
test, then you must describe why your composition deviates 
from the rule and how your ACO will achieve meaningful rep-
resentation and participation by ACO participants and Medi-
care beneficiaries. 42 C.F.R. §425.106(c).

   b. Operations and Duties.

   The governing body of your ACO has the responsibility for 
sight and the strategic direction of your ACO’s operations, 
and must hold management accountable for its activities. 42 
C.F.R. §425.106(b). Specifically, the governing process must 
be transparent. The members of the governing body must have 
a fiduciary duty to your ACO and act in accordance with that 
fiduciary duty. Id. § 425.106(b)(1)-(3).

   To further these objectives, CMS included in the Final Rule 
conflict of interest safeguards that apply to your ACO’s govern-
ning body. Specifically, your ACO must establish and imple-
ment a conflict of interest policy that requires each member of 
the governing body to disclose all relevant financial interests 
and defines a procedure to determine whether a conflict of in-
terest exists and resolving such conflicts to the extent that they 
exist. Id. § 425.106(d). Finally, the conflict of interest policy 
must define remedial actions for governing body members that 
fail to comply with the policy. Id.

3. What substantive provisions must be included in the con-
tractual agreements between your ACO and the providers 
and/or suppliers who participate with your ACO?

   Contractual arrangements between your ACO (on the one 
hand) and ACO participants and ACO providers and suppliers 
(on the other hand) are now governed by new provisions to the 
Final Rule under 42 C.F.R. § 425.116; however, the provisions 
governing agreements applicable to ACO participants and those 
applicable to ACO providers/suppliers are materially identical 
with few exceptions. Id. § 425.116(a) and (b).

   There are nine requirements applicable your ACO’s agree-
ments with ACO participants. First, the parties to the agree-
ments must include only your ACO and the ACO participant. 
Id. § 425.116(a)(1). This requirement reflects CMS’ position 
that independent practice association and physician-hospital
organization contracts are not appropriate or required for purposes of participation in the MSSP.

Second, the signatories to the agreements must be only individuals who are authorized to bind the ACO and the ACO participant. Id. § 425.116(a)(2). Third, the agreements must state that the ACO participant agrees to participate in the MSSP and to comply with the requirements of the MSSP as well as all of the laws and regulations applicable to the program. Id. § 425.116(a)(3). Similarly, the ACO participant must agree to ensure that each ACO provider/supplier billing through the TIN of the ACO participant agrees to the same participation and compliance obligations as the ACO participant itself. Id.

Fourth, the agreements must define the ACO participant’s rights and obligations in, and representation by, the ACO. Id. § 425.116(a)(4). These requirements include: (i) quality reporting requirements; (ii) beneficiary notification requirements; and (iii) a description of how participation in the MSSP affects the ability of the ACO participant and its ACO providers/suppliers to participate in other Medicare demonstration projects or programs that include shared savings mechanisms. Id.

Fifth, your ACO agreements must identify how the opportunity to obtain shared savings will encourage the ACO participant to adhere to the quality assurance and improvement program and evidence-based medicine guidelines established by the ACO. Id. § 425.116(a)(5).

Sixth, your ACO agreements must require the ACO participant to update its enrollment data, including the addition and deletion of ACO professionals and ACO providers/suppliers billing through the TIN of the ACO participant, on a timely basis in accordance with the Medicare program requirements and to notify the ACO of any such changes within 30 days after the change. Id. § 425.116(a)(6).

Seventh, your ACO agreements must allow the ACO to take corrective action against the ACO participant, including a corrective action plan, denial of incentive payments, and termination of the ACO participant agreement, to address non-compliance with the MSSP and other program integrity issues. Id. § 425.116(a)(7). Similarly, the agreement must ensure that the ACO participant implements similar measures with its ACO providers/suppliers. Id.

Eighth, the term of your ACO agreements be for at least one year, and identify the consequences for early termination. Id. § 425.116(a)(8).

Finally, your ACO agreement must include completion of a close-out process upon the termination or expiration of the agreement that requires the ACO participant to provide all data necessary to complete the annual assessment of your ACO’s quality of care and other relevant matters. Id. § 425.116(a)(9).

The provisions applicable to direct agreements between your ACO and ACO providers/suppliers include all of the provisions (1) – (7) above, which are applicable to contracts between your ACO and ACO participants. Id. § 425.116(b)(1) – (7).

Given the time required for (and complexity of) implementation of these provisions, CMS has given your ACO until January 1, 2017 to satisfy these contractual compliance requirements. Your ACO must submit executed ACO participant agreements for each ACO participant at the time of its initial application, renewal process, and when adding to its list of ACO participants. Id. § 425.116(c).

If you have any questions about the compliance status of your ACO, please contact John D. Shire at (202) 696-1477 or jshire@foxrothschild.com.

About the Author
A partner in Fox Rothschild’s Washington, DC, office, John D. Shire is a corporate and transactional attorney who represents public and private companies at the leading edge of innovation in the health care, energy, financial services and technology industries as outside general counsel as well as in buy-side and sell-side mergers and acquisitions, joint ventures, commercial contracts and private capital transactions. He also represents clients before federal and state agencies and licensing authorities in connection with compliance matters. Among the services he provides to clients operating in the health care space, John is well-versed in handling matters related to the intricacies of Accountable Care Organization (ACO) structure and clinical integration. John can be reached at jshire@foxrothschild.com

Footnote
1The Final Rule codifies existing CMS guidance and is designed to reduce administrative burden and improve MSSP function and transparency in the following categories: (i) data-sharing requirements; (ii) relationships between ACOs and the providers and suppliers that participate in the ACO arrangement; (iii) clarifications and updates to application requirements; (iv) eligibility requirements governing the number of beneficiaries in the ACO, obligatory processes for coordinating care, legal structure and governance; (v) assignment methodology; (vi) financial performance metrics; and (vii) issues governing program integrity and transparency. 80 Fed. Reg. 32692, 32694 (June 9, 2015). In order to achieve these objectives, CMS, in the Final Rule, adopted the following changes to the MSSP program: (i)–(vii).
The Devil Opportunity is in the Detail.

You have data. You need insight.
CBIZ KA Consulting Services, LLC

- Financial Modeling
- Clinical Benchmarking
- Revenue Integrity
- Eligibility and DSH Services
- Charge Evaluation
- Risk Reduction (RAC)

Information. Not Intuition.

1-800-957-6900
www.kaconsults.com
Thank God for hospital inefficiencies (tongue in cheek)! Well upcoming New Year finds me more contemplative than last year in that we are two years into the ACA and not much has changed. Much like other “sandwich generationers”, I find my loved relatives and friends using more and more of healthcare without experiencing the promises posited by the insurance companies, the ACA and ACOs. Delays in care, lack of “quarterbacking” and inefficient provision of care have provided me with plenty of subject matter to ponder as I try to fill the gaps for others and hopefully myself, before I really need to dive into the deep end of the pool. While many hospitals and affiliated insurers are setting up ACOs, there has not proven to be enough efficiencies in general to control costs and the runaway inflation rates that will hit premiums in 2016 and beyond. That said, how can you be a winner going forward and not be left out in the cold as a non-par facility or provider?

1. Transparency should be a big to do! With high-deductible plans and co-pays exceeding a night on the town, many consumers want to know what a service is going to cost. Don’t try to rationalize we are 24/7 facility and therefore our prices are worth 5 times what they should be. Develop fair and reasonable pricing, zero based and process driven pricing. Charging a patient for laying around while you fix your CT should not be given. The axiom, good news travels fast, bad news moves at the speed of light should keep you on your toes; burn someone with a huge bill, they are very unlikely to use you again.

2. Manage by walking around! When I was acting CFO, I was surprised by how many patients, physicians and nursing staff never saw an executive outside of the C-Suite. Understanding staffing, inefficiencies and patient issues starts with getting involved and trying to understand how the pieces come together. An added benefit is also derived from this activity in that as the key operative in the budget process, you may get some great ideas on how to achieve #1.

3. Not serious about being a team player, better look to be a second tier hospital! New Jersey’s largest BCBS Plan has rolled out a new insurance program that has low to no deductibles for Tier 1 Plans. The downside of being a Tier 2 hospital is you may be chasing money that just will be hard to collect. The lesson to be learned is cash is King! Try to get your doctors on the same page relative to quality and price and you can come out a winner.

4. Remember, above all do no harm! While really the motto of the AMA, healthcare professionals should heed this advice. When is the last time your medical staff looked at the validity of tests and their usefulness? Recently, FDA investigators conducted 20 case studies involving tests used for cancer, autism, Lyme disease and heart disease and found wide-ranging, systemic problems. It was reported that a blood test for ovarian cancer was used despite no evidence it was effective, increasing the risk of false positives and subsequent unnecessary surgery. Similarly, inaccurate test results indicating fetal abnormalities have led women to get abortions, according to the report, while more than 150,000 people given tests for a genetic variant that possibly increases heart disease risk were likely over- or undertreated with cholesterol-lowering drugs. With so many hospital and physician staffs aligning care plans, this area is ripe for yielding better financial outcomes without harm to patients.

5. Better get ready for bundling! No not the pre-marital kind, but bundled payments. Medicare (CMS) just came out with its Hip and Knee program. Many insurers are eyeing similar programs for other common procedures. Better to be eyeballing the crystal ball to prepare for what’s coming than looking in the mirror seeing what opportunities have passed you by, or worse yet the business you lost due to your competitors taking advantage of the opportunity.

6. Don’t ever soil where you want to walk again! Several hospitals have become notorious for going out of network and dropping huge bills on everyone from insurers continued on page 20
to policy holders. You may get away with it short term, but in the long run you will not be on anyone's go to list. Fail to go after co-pays and deductibles of insureds and you face the possibility of lawsuits for insurance fraud. Better to make friends then to alienate anyone! Keep charges/fees reasonable and you will have happy physicians too. Anyone who has told an insurer to take a long walk off a short pier knows how much harm it can cause to your admitting physicians to resent your institution.

7. I said it last year and I'll say it again, mergers and affiliations still may be a good idea if you have not done it yet; if you have merged or affiliated with another facility, still keep your eye on the principles that will make you successful with insurers:
   a. Continue to refine processes and care management plans to insure that you will be adding value to any insurance product or IDS.
   b. Focus on creating economies of scale- you don't need to offer twenty brands of sutures or 5 brands of pacemakers. In a bundled fee environment, you must be able to partner with physicians to drive quality and cost effectiveness while reducing variability in outcomes.
   c. If you have not thought about the entire continuum of care, it is time to make alliances with care providers outside of your assembled skill sets; time to think about home IV, DME providers, home health, visiting nurse services and others!
   d. FFS will yield to value based contracts, how quickly you adapt bodes well for your long term viability. If new to the process, start small with something that you do better than others. Build the data capabilities and reporting mechanisms to ensure your ability to provide timely information to your providers and insurance partners.
   e. Cut the fat! Bloated administration and overhead costs will not make you more attractive to insurers, trimming should be done prudently.

8. Beware of exiting insurers! United Healthcare has made it quite public that it plans to leave a number of states exchange plans. Monitor the insurers that you do business with, many start up ACA plans are also struggling or bankrupt. Better to anticipate payor issues than to be in bankruptcy court trying to collect pennies on the dollar.

9. Are you patient friendly yet? No not just giving them a bill they can read, but giving them tools to manage their health! Patient engagement via social media, Twitter, Facebook and other applications is key to aligning healthy (and not so healthy) consumers to your brand. You want to get your message and value out to your patient base just like insurers have done for years.

10. If you have not reviewed it yet, download a copy of the 2016 OIG Workplan at http://oig.hhs.gov/reports-and-publications/archives/workplan/2016/oig-work-plan-2016.pdf. Fraud and quality measures still top the list, but there are many other trending issues that may concern you if you are part of an integrated healthcare organization.

11. Lots of work to be done here! As patients gain more control over their healthcare and demand more of a role in the decision-making process, hospitals, doctors and front-line workers must learn to engage patients. Sensitivity training about patient empathy skills, how to teach patients what they need to know to stay healthy and not return to the hospital Healthcare is mystifying and scary, if you can help people deal with their issues it will pay off in spades!

12. A Press Ganey study (http://go.questexweb.com/kM0zQ0u507C01QeWZJ0e30F) reported that improving nurses’ work environment has been a major priority within the hospital industry, particularly with regard to bullying behaviors. Other providers have looked to improve outcomes by applying for status as “magnet” hospitals, which research shows improves nursing outcomes and working conditions. Remember the old axiom, a good nurse can make a better doctor!

13. Defend your data! HIPAA security requirements will become even more stringent in the near future due to major cyber breaches noted throughout 2015. Remember that your data in a cloud environment is still your data and you are responsible for protecting it! If you have not performed intrusion and vulnerability studies, you should or it could cost you dearly on a financial as well as reputational basis. Last but not least, update your cyber coverage, it is insurance you cannot afford to be without!

Happy 2016! I can virtually guarantee that if you apply this advice, you will be here to read my 2017 New Year's advice!

About the Author
Lew Bivona is President of Professional Medical Management Consultants which assists providers in transitioning to ACA risk modeled products. Lew has over 36 years of experience in rolling out managed care products, both on the provider and insurer sides of healthcare. PMMC coordinates healthcare entities transitions by delivering results without straining budgets. Contact Lew at lewcpa@gmail.com.
### 2015-2016 Chapter Committees and Scheduled Meeting Dates

**NOTE**: Committees have use of the NJ HFMA Conference Call line. The Call in number is (712) 432-1212

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

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

<table>
<thead>
<tr>
<th>COMMITTEE</th>
<th>CHAIRMAN/EMAIL/ PHONE</th>
<th>CO-CHAIR/EMAIL/ PHONE</th>
<th>SCHEDULED MEETING DATES*/TIME</th>
<th>MEETING LOCATION</th>
<th>BOARD LIASON</th>
</tr>
</thead>
<tbody>
<tr>
<td>CARE (Compliance, Audit, Risk, &amp; Ethics)</td>
<td>Susan Hatch <a href="mailto:shatch@virtua.org">shatch@virtua.org</a> (856) 355-0723</td>
<td>Lisa Hartman Weinstein/Deborah Carlino <a href="mailto:lisahartman@hotmail.com">lisahartman@hotmail.com</a> / <a href="mailto:carlind@csrc.rutgers.edu">carlind@csrc.rutgers.edu</a> (646) 458-5683 / (973) 972-3260</td>
<td>First Thursday of the Month 9:00 AM Access Code: 274-926-602</td>
<td>Meeting in person at Deloitte &amp; Touche, Princeton, NJ for Oct., Jan., April and July Balance are calls. Please call to confirm</td>
<td>Tony Parisco <a href="mailto:apa@wilfhome.com">apa@wilfhome.com</a> (973) 899-8949</td>
</tr>
<tr>
<td>Communications</td>
<td>Elizabeth Litten <a href="mailto:ELitten@foxrothschild.com">ELitten@foxrothschild.com</a> (609) 896-3600</td>
<td>Al Rothkamp <a href="mailto:acri@230ad.com">acri@230ad.com</a> (201) 925-3705</td>
<td>First Thursday of each month 9:30 AM Access Code: 549-853-204</td>
<td>Fox Rothschild offices 907 Lexon Dr Bldg 3 Lawrenceville, NJ</td>
<td>Brian Hertman <a href="mailto:bherman@230ad.com">bherman@230ad.com</a> (609) 918-0500 x131</td>
</tr>
<tr>
<td>Education</td>
<td>Mike McKeever <a href="mailto:mmckeever@saintpetersuh.com">mmckeever@saintpetersuh.com</a> (732) 745-8600 x5089</td>
<td>Mary Cronin &amp; Stacey Bigos <a href="mailto:mrcronin@230ad.com">mrcronin@230ad.com</a> / <a href="mailto:sbigos@nja.com">sbigos@nja.com</a> (732) 838-1217 / (609) 273-4017</td>
<td>First Friday of each month 10:00 AM Access Code: 207-716-667</td>
<td>Conference Calls</td>
<td>Scott Mariani <a href="mailto:smariani@wilfhome.com">smariani@wilfhome.com</a> (973) 899-8949 x420</td>
</tr>
<tr>
<td>Certification (Sub-committee of Education)</td>
<td>Rita Romeu <a href="mailto:Romeur@comcast.net">Romeur@comcast.net</a> (973) 418-6071</td>
<td></td>
<td>First Friday of each month 10:00 AM Access Code: 207-716-667</td>
<td>Conference Calls</td>
<td>Mike McKeever <a href="mailto:mmckeever@saintpetersuh.com">mmckeever@saintpetersuh.com</a> (732) 745-8600 x5089</td>
</tr>
<tr>
<td>FACT (Finance, Accounting, Capital &amp; Taxes)</td>
<td>Richard Baum <a href="mailto:rbaum@pinnaclehealth.org">rbaum@pinnaclehealth.org</a> (585) 643-3377</td>
<td>Katie Kelly <a href="mailto:k.kelly@bakerlilly.com">k.kelly@bakerlilly.com</a> (848) 467-3866</td>
<td>Second Wednesday of each Month 8:00 AM Access Code: 587-991-674</td>
<td>Conference Calls</td>
<td>Megan Byrne <a href="mailto:megan.byne@bakerlilly.com">megan.byne@bakerlilly.com</a> (732) 516-4696</td>
</tr>
<tr>
<td>Institute 2015</td>
<td>Jennifer Venegas <a href="mailto:jvenegas@taft.com">jvenegas@taft.com</a> (973) 614-9100</td>
<td>Mike McKeever <a href="mailto:mmckeever@saintpetersuh.com">mmckeever@saintpetersuh.com</a> (732) 745-8600 x5089</td>
<td>Fourth Thursday of each Month 8:00 AM Access Code: 408-966-100</td>
<td>Conference Calls</td>
<td>Heather L. Weber <a href="mailto:heather.wible@bakerlilly.com">heather.wible@bakerlilly.com</a> (848) 467-3858</td>
</tr>
<tr>
<td>Membership Services/ Networking</td>
<td>Maria Facciponti <a href="mailto:mfacciponti@adreima.com">mfacciponti@adreima.com</a> (973) 614-9100</td>
<td>Peter Demos/Brittany Pickell <a href="mailto:pdemos@meridianhealth.com">pdemos@meridianhealth.com</a> / <a href="mailto:BPickell@ConvergentUSA.com">BPickell@ConvergentUSA.com</a> (732) 221-0785</td>
<td>Call for meeting arrangements Access Code: 808-953-286 Locations alternate by month - please contact the chairs</td>
<td>Jennifer Shimek <a href="mailto:jshimek@childrens-specialized.org">jshimek@childrens-specialized.org</a> (973) 912-6167</td>
<td></td>
</tr>
<tr>
<td>Patient Access Services</td>
<td>Dara Derrick <a href="mailto:dderrick@hct.org">dderrick@hct.org</a> (908) 690-6870</td>
<td>Maria Lopes-Tyburczy <a href="mailto:NLopes-Tyburczy@smmcnj.org">NLopes-Tyburczy@smmcnj.org</a> (973) 887-5303</td>
<td>6/11/15, 9/10, 11/11, 1/14/16 (SMCC) 3/10/16 (TBD), 5/12/16 2:30 PM Access Code: 542-364-749</td>
<td>Arego Office Iselin, NJ unless otherwise indicated</td>
<td>Belinda Puglisi <a href="mailto:BPugli@childrens-specialized.org">BPugli@childrens-specialized.org</a> O: (908) 301-5458 / C: (862) 251-0753</td>
</tr>
<tr>
<td>Patient Financial Services</td>
<td>Steven Stadtmauer <a href="mailto:ststadtmauer@csande-bj.com">ststadtmauer@csande-bj.com</a> (973) 778-1771 Ext. 146</td>
<td>Marie Smith <a href="mailto:msmith1@rbmc.org">msmith1@rbmc.org</a> (732) 324-5053</td>
<td>Second Friday of each Month 10:00 AM Access Code: 714-899-796</td>
<td>New Jersey Hospital Association Board Room</td>
<td>Josefette Portaltain <a href="mailto:jportaltain@valleyhealth.com">jportaltain@valleyhealth.com</a> (201) 291-6017</td>
</tr>
<tr>
<td>Payer and Provider Services</td>
<td>Jill Squires <a href="mailto:Jill.Squires@AmeriHealth.com">Jill.Squires@AmeriHealth.com</a> (609) 662-2533</td>
<td>Mike Ruiz <a href="mailto:mrazdesomocurcio@RegionalCancerCare.org">mrazdesomocurcio@RegionalCancerCare.org</a> (201) 510-0924</td>
<td>Third Wednesday of each Month 2:00 PM Access Code: 202-013-321</td>
<td>alternating locations United Healthcare, Iselin, NJ Horizon BCBS, Wall Township, NJ</td>
<td>Kevin Joyce <a href="mailto:kjoyce@acucarenc.org">kjoyce@acucarenc.org</a> (732) 562-7623</td>
</tr>
<tr>
<td>Physician Practice Issues Form</td>
<td>Jennifer Shimek <a href="mailto:jshimek@chnp.org">jshimek@chnp.org</a> (973) 912-6167</td>
<td>Dana Quinn <a href="mailto:Dana.Quinn@CancerPointHealth.org">Dana.Quinn@CancerPointHealth.org</a> (201) 388-0637</td>
<td>11/12/15, 1/14/16, 5/12/16 7/14/16, 9/8/16 9:00 AM Access Code: 703-211-177</td>
<td>Conference Calls Sept. &amp; Jan meetings will also be in person room TBD</td>
<td>Deborah Carlino <a href="mailto:carlind@csrc.rutgers.edu">carlind@csrc.rutgers.edu</a> (973) 972-3280</td>
</tr>
<tr>
<td>Regulatory &amp; Reimbursement</td>
<td>Kathryn Gibbons <a href="mailto:kgibbons@meridianhealth.com">kgibbons@meridianhealth.com</a> (732) 791-3372</td>
<td>Peter Demos <a href="mailto:pdemos@meridianhealth.com">pdemos@meridianhealth.com</a></td>
<td>Third Tuesday of each Month 9:00 AM Access Code: 175-802-794</td>
<td>Monmouth Shores Corp. Park Meridian Conf, Room 1C 1350 Campus Pkwy, Neptune</td>
<td>Scott Besler <a href="mailto:sbesler@bakerlilly.com">sbesler@bakerlilly.com</a></td>
</tr>
<tr>
<td>Revenue Integrity</td>
<td>Betsy Weiss <a href="mailto:BWeiss@FranciscanMedical.org">BWeiss@FranciscanMedical.org</a> (609) 598-5347</td>
<td>Eric Shubin <a href="mailto:EShubin@craneware.com">EShubin@craneware.com</a> (810) 772-1374</td>
<td>First Wednesday of each Month 9:00 AM Access Code: 351-605-588</td>
<td>Princeton HealthCare System</td>
<td>Tracy Davison-Dicanto <a href="mailto:Tdavison-dicanto@princetonhs.org">Tdavison-dicanto@princetonhs.org</a></td>
</tr>
<tr>
<td>CPE Designation</td>
<td>Lew Bivona <a href="mailto:lbivona@verizon.net">lbivona@verizon.net</a> (609) 254-8141</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Can you share some insights about the results of the recent Hospital Population Health Survey release by the AHA?

The American Hospital Association’s (“AHA”) Health Research & Educational Trust, in conjunction with the Association for Community Health Improvement, conducted a survey of hospitals across the nation, mailing out 6,365 copies and receiving a response rate of 22%; or just over 1,400 surveys. This survey was used to gauge the number of hospitals committed to population health using a self-assessment in which the hospitals ranked their commitment on a scale from “no commitment” to “total commitment.”

Background of Study Participants

The AHA survey, entitled “Approaches to Population Health in 2015: A National Survey of Hospitals”, was sent out to nearly 6,400 hospitals across the nation including those in different regions and those of different sizes, in order to accurately examine commitment to population health across the United States. However, with a response rate of only 22%, only 1,418 surveys were completed and returned to the AHA. Thus, when the sample percentages of certain groups were compared to their national percentages, some groups were overrepresented while others were underrepresented. Among the overrepresented groups are the geographical region of the Midwest, large hospitals (300+ beds), teaching hospitals, and not-for-profit hospitals, whereas the Southeast and Southwest regions were underrepresented. In addition to looking at hospital location and size, the survey also took into account governing authority, such as investor-owned and governmental, and service type, such as rehabilitation or general medical/surgical. It should be noted that of the 1,418 responses, 1,186, or 83.6% of respondents, were from general medical/surgical hospitals.

Key Findings

Perhaps the most significant result of the survey was that 85% of the hospitals reported strong or total commitment to population health or currently have population health in their vision statement, showing that a vast majority of hospitals want to improve the health of their populations as a whole. In fact, over 90% of the hospitals agreed that population health was in conformity with their mission statements, but a relatively low percentage (< 20%) strongly believe their hospitals have the financial resources equipped for handling population health or have the programs to address socioeconomic determinants of health.

Hospitals form different levels of partnerships within their communities, ranging from funding, networking, collaboration, or an alliance. Not surprisingly, a majority of hospitals are in some sort of partnership with other hospitals in order to exchange ideas and information and, in the cases of collaborative relationships and alliances, share resources and activities to enhance the capacity of their partner(s). Specifically, 87% of the hospitals that participated in this survey reported being in some type of partnership with other local hospitals. Conversely, hospitals also partner with local governments, state agencies, and other agencies, such as faith-based organizations and postsecondary education facilities. In fact, the most common partnerships are with public health departments, chambers of commerce, health insurance companies, and federally qualified health centers/community clinics. The agencies least likely to be partnered with hospitals, however, approximately 50% of the time are partners, are transportation and housing/community development authorities. Overall, 69% of hospitals reported involvement in a community-wide coalition.

To integrate population health into each hospital’s strategic plan, community health needs assessments (“CHNA”) are conducted in order to identify and evaluate health-related needs in the community to which the hospital belongs. This “community” is often times representative of the “population”, as in population health, since 70% of hospitals consider patients that use their health system as their populations and 69% consider the geographic service area as their popula-
tion. In addition to being a requirement for all tax-exempt hospital facilities under Internal Revenue Code §501(r)(3), CHNAs have several uses; the most important of which are as follows:

- To integrate population health into the hospital’s strategic or operational plan;
- To target programs or services to improve population health;
- To increase collaboration with community partnerships to address identified needs;
- To target programs or services to improve population health in collaboration with public health departments;
- To assess the impact of hospital resources and community readiness to address health needs; and
- To use baseline data to inform future assessments.

Conclusion

Despite commitment to population health and the completion of CHNAs, hospitals still face many challenges in the pursuit for implementation of population health. As stated, these problems include a lack of financial resources, which many hospitals try to alleviate through relationships. In addition, certain types of partnerships amongst hospitals help improve programs to address socioeconomic determinants of health. Although CHNAs do help to overcome certain barriers, such as identifying the needs of the community and prioritizing these needs, there are also additional challenges, the most pressing being implementation of an action plan, which is the plan on how to implement changes in the hospital towards achieving population health. With nearly 85% of hospitals reporting strong or total commitment to population health, a large shift is occurring in how hospitals go about providing care to patients. However, it is important to remember that the survey results are only representative of 22% of the total surveys mailed to hospitals across the country and the information reported herein may differ from those hospitals which elected not to participate.

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.

We know the risks

We have the solutions

New Jersey’s Leading Hospital/Healthcare Insurance Broker

We provide our clients with the best combination of coverage, pricing and risk management.

WILLIAM H. CONNOLLY & CO., LLC

Insurance and Risk Management

56 Park Street/Montclair, NJ  07042-2999
973.744.8500   fax: 973.744.6021
www.whconnolly.com
The Lacuna by Barbara Kingsolver. Fiction that weaves around historical events (from 1920s through early 50s) in Mexico and US and paints colorful and nuanced portraits of artists and politics.

Recommended by Elizabeth Litten

Our Iceberg is Melting (Changing and Succeeding Under Any Conditions) by James Kotter. It is a fable about penguins and change because their iceberg may have been melting. Thinking outside the box theme.

Recommended by Joe Dobosh

Unbroken by Laura Hillenbrand. I like fiction that has a place in our history and it is well written and exciting. You should also see the movie

Recommended by John Hailperin

“A Perfect Mess: The Hidden Benefits of Disorder - How Crammed Closets, Cluttered Offices, and on-the-Fly Planning Make the World a Better Place” by Eric Abrahamson and David H. Freedman. The title of this book caught my attention at our local library and I listened to it as an audiobook. As the title suggests, the premise of the book is that a little disorder can actually make systems more effective. While we live in a culture that prizes organization, neatness and tight schedules, this book examines how messy systems can be more effective than highly organized ones. The authors provide true stories and case studies of the hidden benefits of mess. My favorite examples involved an experiment using a deck of cards and the chapter on randomness. I was able to apply the lessons learned from these examples to real life situations. So, whether you are a neatnik or a slob, you just might be intrigued by what the authors have to say about mess.

Recommended by Betsy Weiss, St. Francis Medical Center
A Different Model of Care

by Scott Millard

Connor was born on March 1, 1999, but that is not when his story started. When his mom, Deb, was 12 weeks pregnant an abnormality was found on the ultrasound that the doctors felt quite sure would be fatal. Yet despite the dire predictions, the pregnancy continued, and appeared to be fairly normal.

Without prior warning, at 30 weeks and 5 days Deb went into pre-term labor. Despite their efforts to stop the process, two days later Connor was born very blue and not breathing. After eight long weeks, the NICU doctors, geneticists and myriads of specialists at the local hospital where Connor was born, had succeeded in identifying a very long list of concerns and problems, but they still had no idea what the causes were. Because of this, and Connor’s worsening condition, we decided it was time for a second opinion, so we transferred Connor to a leading children’s hospital.

I guess depending on how you look at it you could say our timing was either great or terrible. Within 12 hours of arriving Connor was back on a ventilator. Within 24 hours he had coded, was having burst suppression seizures and was the lucky recipient of a bedside emergency tracheotomy. The list of problems was getting longer but still not a single definitive answer to that all important question, ‘why’? With all the focus on the problems and issues, trying to understand and keep track of the different treatments and machines that Connor was reliant on to sustain his life, the actual person, this precious little life almost got lost; a sweet, beautiful boy with blond hair, hazel eyes, a spunky, tenacious spirit, and a family who loved him dearly.

While most of the medical community continued to try and answer all their ‘why’ questions and encouraged us to begin thinking about rehab hospitals and placing him in a long term care facility; we started asking a different question. Why can’t we? Why can’t we do what other parents do? Why can’t we learn his care, take him home, and be his mom and dad? You would be amazed at what you can accomplish if you are willing to question the status quo.

When Deb got pregnant with Connor we had hopes and dreams for him, and our family. Hopes and dreams that are probably not unlike the ones you have for your family. However, families like ours, families of children with life-shortening conditions, face a different set of obstacles that often make the realization of those dreams impossible. Caring for a child with complex health care needs at home is an exhausting and often isolating experience. Instead of being mom and dad, parents are forced to become: nurse, therapist, insurance specialist, teacher and care coordinator. And, just like we did, the majority of the families that find themselves in these types of situations find themselves without adequate community based supports to help them succeed and thrive.

For the eight and a half years we were blessed to have Connor with us we had two overarching goals. To never let his medical issues prevent him from doing anything that brought him joy and to keep him out of the hospital. Along the way, we were fortunate enough to have a medical team, family, friends, a church community and an employer that supported us; but many families facing similar situations do not have the type of

continued on page 26
support system we had. This inspired the dream for Connor’s House: to help other families with complex health care needs embrace every day and live life to its fullest!

According to the Children’s Hospice International, there are currently 1.2 million children in the U.S. who suffer from life-shortening illnesses¹ and most of their families are overwhelmed because there are few, if any, care and support services readily accessible to them outside of an in-patient hospital or long term care setting.

The lack of community based family supports such as care coordination, integrative therapies, short break respite care, and alternatives to end-of-life care delivered in the hospital, greatly diminishes the quality and integrity of family relationships, careers and other typical aspects of every day life. Additionally, the ability for other family members to be involved in the normal activities of every day life is significantly limited by the demands placed upon them in order to care for their sick child at home. In order to keep Connor at home, Deb was forced to give up her career to become his full-time caregiver. Fortunately for us this did not create a financial hardship. Many families in similar situations do not have this luxury.

In the United States the pediatric palliative care model, while still in its infancy, has largely been developed and implemented almost exclusively within large acute care medical centers. As such, the limited services that have been implemented tend to be very medically and symptom management focused, and largely designed to be delivered during inpatient hospital stays. Furthermore, most of these services inadequately address the emotional, social and spiritual elements of the family’s journey.

Palliative care remains misunderstood by large parts of the medical community as being equivalent to hospice care and as such referrals for these services, where they exist, is often only considered during end-of-life situations. This misunderstanding prevents many families from receiving support services that could have a significant positive impact on the quality of life for both the sick child and the entire family. There are several fundamental differences between palliative care and hospice care; the primary one being that hospice care is limited to end-of-life situations, the last six months of life, typically once curative treatment has been abandoned. Palliative care services in contrast can, and should, be delivered immediately after diagnosis or the onset of symptoms and continuing throughout the disease progression concurrent with appropriate curative treatments.

Palliative care is best implemented by an integrated interdisciplinary team. If the child and family are supported by multiple medical professionals or service providers, the identification of a care coordinator is crucial to its success. Unfortunately the U.S. health care system currently promotes specialist care and competition, instead of cooperation amongst service providers and whole person care.

Additionally, because Medicaid and private insurance providers do not cover pediatric palliative care services, the services offered are limited by a lack of available philanthropic funding. This problem is compounded by the fact that the majority of current medical reimbursement contracts are procedure driven, which can create conflicts with the implementation of palliative care concepts that focus primarily on overall quality of life.

In 2003, 82% of the children (ages 0-19) that died in the U.S. died in the hospital and just 15% of deaths occurred at home. However, 70% of families would choose for their child to die at home if adequate supports were available³. In the UK, where there is a robust network of freestanding children’s hospice houses and other community based supports, only 32% of childhood deaths occur in the hospital³.

According to Together for Short Lives UK, there are approximately 49,000 children with life shortening conditions in the United Kingdom⁴. They currently have over 50 freestanding children’s hospices as well as other community-based programs to help support these families. By contrast, in the United States there are currently only two operational freestanding children’s palliative care homes to support the 1.2 million children with chronic life threatening conditions.

Not only does a palliative care model improve quality of care but it could also reduce costs. The state of Massachusetts estimates that it costs $178,000 to care for a child in an intensive care unit during the last 17 days of life and these costs include very limited or no therapeutic, psychosocial or bereavement supports. Of the 53,000 children who died in 2005 only 2.2%
died under hospice care. By contrast end of life care for the last 17 days of life in freestanding palliative care home, with a full compliment of therapeutic, psychosocial and bereavement support could be delivered for under $35,000. And, it could be delivered for even less at home.

There are numerous medical centers throughout the northeast where families can receive excellent acute pediatric medical care, yet there is not a single comprehensive community based pediatric palliative care program to which families of children with complex health care needs or life-shortening conditions can turn to for temporary short-break respite care, psychosocial supports, integrative therapies, alternative location for end-of-life care, or the integrated support services they need from diagnosis through bereavement.

There are many opportunities to help improve the existing models of care for children with complex health care needs and life-shortening conditions. However, success in the current environment will require the creation of new health care regulations, a funding model that is not reliant upon philanthropy or the present system of procedure based reimbursements, as well as a comprehensive education and training program for both medical professionals and families. Providing these families with the holistic, community-based support services they so desperately need, will require bringing together the best ideas and skills from the medical, social service, education and the non-profit sectors in an integrated and coordinated fashion.

Free standing pediatric palliative care facilities do not replace acute care medical centers, outpatient clinics or private physician care; instead, they complement their work by delivering services that effectively address the gaps in the current care models for children with complex health care needs and life-shortening conditions allowing families to once again focus on enjoying life and one another.

Pediatric palliative care services, when fully implemented in an integrative community based model, will reduce the number and length of hospital stays and free the staff at the acute care medical centers from the time consuming care coordination and social service roles that they currently undertake, largely out of their goodwill, with limited to no reimbursement. This creates the possibility for a new contribution model to fund community based palliative care programs based on reduced costs for insurance companies and increased productivity of the staff at acute care medical centers.

Connor’s House was founded based on the belief that enhancing the quality of life for families of children with life shortening conditions would take a community coming together led by an independent non-profit organization that is uniquely positioned to help bridge the gaps in the existing, fractured, model of care.

Connor’s House seeks to provide family-centered support services including short-break respite care, parent and sibling support groups, integrative therapies, spiritual guidance, social networking, educational programs, resources and referrals, and an alternative place of death for families who do not wish to spend their child’s last days in an acute care facility but are not comfortable or prepared to go through that experience in their own homes. Connor’s House will utilize a holistic approach to care, combining traditional and alternative therapies to help maximize the comfort of both the child and their family.

While there are significant barriers to overcome, the addition of a resource center like Connor’s House, would be the missing link that is so desperately needed for children with complex health care needs and their families. It would bridge the gap between hospital and home, allowing families to focus on what really matters, living life, building memories and loving each other.

Footnotes
1 Children’s Hospice International 13th Annual ChiPACC Conference, April 16, 2014
2 NHPCO Facts and Figures: Pediatric Palliative and Hospice Care in America, Sarah Friebert MD, April 2009.
4 togetherforshortlives.org.uk, accessed 11/15/2015
The Costs of Medical Privacy Breach

Reprinted with the permission of *MDAdvisor*, A Journal for the New Jersey Medical Community

by John Zen Jackson, Esq.

“Whatever, in connection with my professional practice, or not in connection with it, I see or hear in the life of men, which ought not be spoken of abroad, I will not divulge as reckoning that all such should be kept secret.”

*The Hippocratic Oath*

The stakes for failing to adhere to adequate protections for patient medical confidentiality keep getting higher. In addition to the already frightening scope of penalties and problems that might follow a breach of the HIPAA Privacy Rule, a recent case in Indiana dramatically highlights the increasing risk to a healthcare provider from the wrongful use and disclosure of a patient’s healthcare information. In connection with the HIPAA Privacy Rule, such information and data are termed Protected Health Information (PHI).

On April 14, 2003, compliance with the HIPAA Privacy Rule became mandatory for most covered entities. The Office for Civil Rights (OCR)—the enforcement arm for the Department of Health and Human Services—began to accept complaints involving the privacy of personal health information in the American healthcare system. At that time, it was OCR’s stated intention to pursue enforcement activities through an approach initially emphasizing guidance and technical assistance.1

However, the agency had more coercive tools available to it and with the passage of time it has been employing these more coercive tools with significant impact on healthcare providers. The potential penalties for HIPAA non-compliance range from $100 to $50,000 for violations that occur in the absence of willful neglect to penalties starting at $50,000 in the circumstances of willful neglect. As has been recently noted, for the two-year period of 2011–2012, approximately 15 million individuals had their protected health information compromised through various HIPAA breaches. OCR had assessed penalties of some $3.5 million in 2013 and more than $7 million through the first half of 2014.2

With the enactment and implementation of the Health Information Technology for Economic and Clinical Health Act (HITECH) in 2009, business associate liability for HIPAA breaches was expanded, and state attorneys general received the power to bring HIPAA enforcement actions. There have been several settlements reached in actions brought by the state attorneys general.3

**Breach of Privacy Violations and Penalties**

The Department of Justice in conjunction with the FBI has responsibility for dealing with criminal violations. It is a federal criminal offense for a person to commit any of the following three acts:

1. to knowingly and in violation of the regulations use or cause to be used a unique health identifier
2. to knowingly and in violation of the regulations obtain individually identifiable health information relating to an individual
3. to knowingly and in violation of the regulations disclose individually identifiable health information to another person

The penalties for a criminal violation depend on the circumstances of the wrongful use and disclosure. The penalty may be a fine of not more than $50,000 with imprisonment for not more than one year, or both, with an enhancement of the penalty if the offense is committed under false pretenses with a fine of up to $100,000, imprisonment for not more than 5 years, or both. Most severely, if the offense is committed with the intent to sell, transfer or use individually identifiable health information for commercial advantage, personal gain or malicious harm, the offender can be fined not more than $250,000, imprisoned not more than 10 years, or both.4

The first criminal case was brought in 2004 in the Western District of Washington. It involved a phlebotomist who obtained a cancer patient’s personal information from his health record and used it to fraudulently obtain four credit cards, making charges of thousands of dollars in the patient’s name. The phlebotomist received a 16-month prison sentence.6 Criminal prosecutions, although rare in comparison to the civil enforcement by OCR, continue to occur. In August 2014, a former hospital nurse entered a plea of guilty in the Eastern District of Texas to wrongful disclosure of protected health information for personal gain. In February 2015, he was sentenced to 18 months in federal prison.7
An obligation to preserve patient confidentiality has long been part of licensing schemes and a basis for professional disciplinary actions. Violations of HIPAA regulations have been the basis for a number of physician disciplinary proceedings based on a finding of “professional misconduct.” The New Jersey State Board of Medical Examiners is empowered to ground disciplinary decisions in the violation of any state or federal statute or regulation that the Board is responsible for administering. Reprimands have been issued in New Jersey and elsewhere.

Private Lawsuits for Breach of Privacy Damages

Until 2006, multiple court decisions had repeatedly rejected individual patients’ attempts to base a claim for compensation on breach of the HIPAA regulations. However, this absence of the right to bring private civil damage lawsuits under the HIPAA Privacy Rule has proven to be of limited protection. The potential for a renewed concern regarding HIPAA violations forming the basis for tort claims was recognized. Rather than basing the tort claim on the violation of any provisions of the HIPAA regulations, a claim was formulated as a breach of the common law protection of patient confidentiality with the HIPAA Privacy Rule providing evidence of the appropriate standard of care that was to be observed and which had been breached.

Starting with the 2006 North Carolina decision of Acosta v. Byrum there has been an increasing groundswell of cases recognizing state law claims of violation of physician-patient confidentiality and privacy arising out of conduct that violates the HIPAA Privacy Rule. A similar conclusion has been reached in Missouri, Minnesota, Tennessee, West Virginia and Connecticut. The Connecticut decision from mid-November 2014 even allowed use of the breach of medical confidentiality as protected by the HIPAA Privacy Rule to provide a basis for a class action.

In addition to demonstrating a duty of confidentiality and breach of that duty, a plaintiff asserting the wrongful disclosure of patient information must establish that the breach proximately caused the alleged damages being claimed. Compensatory damages in an action for wrongful disclosure may include recovery for emotional distress, the costs of medical or psychiatric treatment for emotional injuries caused by the disclosure and lost wages or loss of employment. If a patient relies on an invasion of privacy theory, then his or her recovery generally will be based on emotional suffering and injury to the patient’s reputation. A plaintiff may not have to allege a physical injury in order to recover for the emotional distress allegedly caused by the disclosure of confidential medical information. In the absence of catastrophic consequences from the wrongful disclosure, the extent of recovery in these cases is limited. Jury awards were frequently only a few thousand dollars; although, there are some verdicts in excess of $100,000.

Not surprisingly, there have been some verdicts that have included punitive damage awards because of aggravating circumstances.

The Indiana Case: A Clarion Call

Tort exposure arising from conduct in breach of the HIPAA Privacy Rule took on a new dimension with the decision of the Indiana Court of Appeals upholding a jury verdict in favor of plaintiff for $1.8 million. This verdict was reduced by 20 percent for an amount of injury attributable to the conduct of a non-party, with a resulting final award of $1.44 million.

In Walgreen Co. v. Hinchy, the trial court permitted the use of HIPAA as evidence of the standard of care for a pharmacist’s duty of confidentiality and privacy regarding a patient’s protected health information. Pharmacies are considered “covered entities” under HIPAA and, similar to physicians, have a regulatory obligation to maintain confidentiality of patient information.

Plaintiff Hinchy had been having an on-and-off sexual relationship with a Mr. Peterson. Hinchy filled all of her oral contraceptive prescriptions at a Walgreen pharmacy. While Peterson was seeing Hinchy, he also began dating a Walgreen pharmacist named Withers. At some point in the relationship, Hinchy became pregnant with Peterson’s child. Later, Peterson learned that he had contracted genital herpes. After the birth of the child, Peterson informed Withers about both the baby and the possible exposure to herpes. Withers accessed the Walgreens prescription profile for Hinchy to see if she could find any information regarding treatment for sexually transmitted diseases. In the ensuing litigation, Withers claimed that she did not look for information regarding birth control prescriptions and did not reveal any of the information that she had accessed to anyone. The jury did not accept the pharmacist’s version of events.

Peterson had an exchange of text messages with Hinchy in which he berated her regarding the failure to refill her oral contraceptive prescriptions and claiming to have a printout of the record. His remarks were in connection with an attempt to rebuff claims for child support in connection with a paternity lawsuit. Concerned as to how Peterson had this information, Hinchy contacted a Walgreens branch but was informed that there was no way to track whether her records had been accessed. Hinchy took no further action at that time.

About a year later, however, Peterson sent a gift to his son with a return address on the package that Hinchy did not recognize. Through an Internet search, she linked the address with Withers and learned that Peterson and Withers had married. She also learned that Withers was a pharmacist at the local pharmacy where Hinchy filled her prescriptions. Hinchy contacted her local pharmacy to report her suspicions. The Walgreens investigation confirmed that in violation of HIPAA, Withers had accessed Hinchy’s prescription information without consent.

continued on page 30
Hinchy’s lawsuit had several counts of wrongdoing against Withers and claims of vicarious responsibility against Walgreens for Withers’ actions, as well as direct claims based on negligent supervision and training of its employee. Summary judgment was denied, and the case was presented to a jury in July 2013. The jury returned a verdict in favor of the patient and found that the total amount of damages suffered by Hinchy was $1.8 million, that Peterson even though a non-party who was not sued was responsible for 20 percent of the damages and that Walgreen and Withers were jointly responsible for the remaining 80 percent. (The issues involving the employer’s vicarious liability and defenses based on conduct outside the scope of the pharmacist’s employment warrant fuller discussion than this article permits.)

In its review on appeal, the intermediate Indiana Court of Appeals easily found a basis for liability in the negligent breach of a duty of confidentiality on the part of the pharmacist and that Hinchy had provided evidence of resulting damages. The court then rejected the contention that the verdict was excessive in amount. It noted that there was the following evidence of Hinchy’s damages:

- The pharmacist had learned about Hinchy’s private health information, including her social security number, and then shared that information with Peterson, who then shared the information with at least three other people.
- Hinchy’s father learned about her use of birth control, that she had herpes and that she had stopped taking birth control shortly before becoming pregnant.
- Hinchy testified that she experienced mental distress, humiliation and anguish as a result of the breach. She stated that she was upset, crying and feeling “completely freaked out.…” She felt “violated,” “shocked” and “confused.”
- The disclosure led to Peterson berating Hinchy for “getting pregnant on purpose” and eventually extorting Hinchy by threatening to release the details of her prescription usage to her family unless she abandoned her paternity lawsuit.
- Hinchy testified that she experienced uncontrollable crying that affected her ability to care for her child, went to a counselor to address the emotional toll of the privacy breach, experienced a general distrust of all healthcare providers and felt a persistent and continuous loss of “peace of mind.”
- Hinchy also testified that she was now taking Celexa, an antidepressant, which costs $75 per month. Before the breach, she had taken a weaker antidepressant intermittently and had not taken it for more than one year before the breach.

In support of its argument as to excessive damages, the defendant Walgreens contended that: 1) Hinchy did not have a physical injury or condition resulting from the breach, 2) Hinchy had no lost wages as a result of the breach and 3) Hinchy did not offer any testimony from a medical professional or counselor supporting her claim of emotional distress. The court viewed these arguments as a request that it reweigh the evidence, which it would not do. Accordingly, the verdict was upheld. Defendant Walgreens requested that the intermediate Court of Appeals reconsider its ruling. That request was denied as was the Walgreen petition for further review by the Indiana Supreme Court.

**Protective Steps**

The catastrophic potential of such verdicts becoming widespread is underscored by the limited limitations of insurance coverage. Breach of medical confidentiality claims are not automatically encompassed by the protection of medical malpractice liability insurance. Some policies utilize the concept of “medical incident” arising out of or resulting from professional services to preclude coverage for a breach of medical confidentiality. Even when the conduct giving rise to the claim occurs during the performance of professional services so as to come within the definition of “medical incident,” coverage may be denied based on policy exclusions for conduct that violates a statute or based on the characterization of the conduct as an intentional act.

The insurance industry has responded by offering coverage for different aspects of the costs or liabilities that arise from breach of medical confidentiality or from data breaches involving personally identifiable information such as Social Security numbers or dates of birth. The area of “cyber risk” in particular has seen expansion as stand-alone or supplemental coverage. In light of the expanding exposure, these new insurance products are well worth evaluating to assess whether the insuring clauses, definitions and exclusions provide meaningful protection. The cost of such coverage needs to be assessed in terms of the scope of the offered coverage and the potentially substantial monetary penalties or damage awards that can be imposed.

Another fundamental protective step is having in place appropriate policies and procedures for handling confidential patient information and PHI, along with adequate training on privacy concepts and practices for new employees and staff at the start of employment. Furthermore, there should be periodic retraining of HIPAA standards to refresh or update staff. The lack of such basic orientation and education by the employer creates significant vulnerability to liability for various regulatory and tort violations.

In addition to policies and procedures for the healthcare professional’s staff, it is important to have in place so-called Business Associate Agreements with non-workforce personnel and non-employees who nonetheless perform certain functions or activities that involve the use or disclosure of PHI on behalf of, or in providing services to, a covered entity. Such agreements place an obligation on the business associate to adhere to the HIPAA practices and policies of the healthcare professional.
Similarly, making provisions for audits of electronic records to identify inappropriate or suspicious activities or access should be considered by the prudent medical practice or its managers. While audits may not actually be a protective step to prevent a privacy breach, audits permit earlier recognition of a problem and allow for attempts to mitigate and ameliorate any damage.

Lastly, the implementation of the exquisitely simple step of encryption protocols for laptops and other portable data devices cannot be overemphasized. Encryption should not be ignored because of the powerful protection it can provide against inadvertent disclosures. Encryption makes electronically stored data inaccessible or unreadable. Indeed, if encrypted, lost PHI data on a misplaced or lost laptop may well not even be a breach that needs to be reported under HIPAA. While encryption of ePHI can be a powerful source of comfort, the protocols to do so must be done correctly and periodically updated as the technology changes and advances.

It is important for all healthcare professionals to be aware that although HIPAA does not provide a private cause of action, an action for breach of confidential information is likely recognized under state law, and HIPAA may be used as evidence of the appropriate standard of care. Beside the tort exposure, the regulatory penalties can be devastating. Moreover, law enforcement has embraced the notion that the days when medical employees could snoop around patient charts for "juicy" information to share outside the office or hospital are very much gone. Such conduct subjects the offender to criminal prosecution and imprisonment.

About the author
John Zen Jackson, Esq. is certified by the Supreme Court of New Jersey as a civil trial attorney and is a Fellow of the American College of Trial Lawyers. He is a partner in the law firm of McElroy, Deutsch, Mulvaney & Carpenter, LLP and a member of the firm's Health Care Practice Group.

Footnotes
52 U.S.C. § 1320d-6(b).
6United States of America v. Richard W. Gibson, 2004 WL 2237585 (W.D. Wash.)
8NJ.S.A. 45:1-21(b).
9See, e.g., New Jersey State Board of Medical Examiners. (2012, March 14). In the matter of Nikhil S. Parikh, M.D. License No. 25MA04165700; Rhode Island Board of Medical Licensure and Discipline. (2011, April 15). In the matter of Alexandra Thran, M.D. www.health.ri.gov/discipline/MDAlexandraThran.pdf.
11638 S.E.2d 246 (N.C. App. 2006).
18Peed v. Dimension HealthCare Assoc., 2010 WL 7633919 (Md.Cir.Ct.).
2325 N.E.3d 748 (Ind. Ct. App.), transfer denied, 2015 Ind.LEXIS 374 (Ind. 2015).
2745 CFR §164.401 (definitions of “breach” and “unsecured”); and 45 CFR §164.304 (definition of encryption).
### Job Position and Organization

<table>
<thead>
<tr>
<th>Manager Medicaid Billing</th>
<th>Financial Decision Support Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>BARNABAS HEALTH</td>
<td>AtlantiCare</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Accountant</th>
<th>Senior Cost Accountant - Decision Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROCURE PROTON THERAPY CENTER</td>
<td>University Radiology</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Claim Integrity Auditor, RHIA/RHIT/RN - FT</th>
<th>Financial Analyst - Healthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital Health, Lawrenceville, NJ</td>
<td>University Radiology</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Product Specialist - Revenue Cycle/Financial</th>
<th>Director, Patient Accounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCS</td>
<td>Confidential</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Network Director, Revenue Management Resources</th>
<th>Senior Director of Operations</th>
</tr>
</thead>
<tbody>
<tr>
<td>ST. LUKE'S UNIVERSITY HEALTH NETWORK</td>
<td>Robert Wood Johnson Physician Enterprise</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chief Financial Officer</th>
<th>Coordinator</th>
</tr>
</thead>
<tbody>
<tr>
<td>PARTNERSHIP FOR MATERNAL &amp; CHILD HEALTH OF NNJ</td>
<td>Atlantic Health System</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Practice Administrator - Cardiology</th>
<th>Financial Coordinator</th>
</tr>
</thead>
<tbody>
<tr>
<td>ROBERT WOOD JOHNSON PHYSICIAN ENTERPRISE</td>
<td>Englewood Hospital and Medical Center</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Director of Quality Improvement</th>
<th>Revenue Integrity Analyst</th>
</tr>
</thead>
<tbody>
<tr>
<td>ROBERT WOOD JOHNSON PHYSICIAN ENTERPRISE</td>
<td>THE UNIVERSITY OF VERMONT MEDICAL CENTER</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Financial Analyst III</th>
<th>Claim Integrity Auditor, RHIA/RHIT/RN, FT, Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATLANDICARE</td>
<td>CAPITAL HEALTH, LAWRENCEVILLE, NJ</td>
</tr>
</tbody>
</table>
Forty Year Retrospective

by Frank Ciesla

For acute care hospitals, 1975 was a seminal year for rate setting by the Department of Health (“DOH”). Brendan Byrne was sworn in as governor in January of 1974. He had appointed Joanne Finley as his Commissioner of Health and James J. Sheeran as his Commissioner of Insurance.

The system for setting the reimbursement rates paid by Blue Cross, was described by a court in 1973 as:

Plaintiffs’ contention overlooks the fact, however, [***7] that neither Blue Cross nor the hospitals control how much Blue Cross reimburses the hospitals for services rendered to Blue Cross subscribers. That function is vested in the Commissioner of Insurance of the State of New Jersey with the approval of the Commissioner of Health of the State of New Jersey by virtue of the Health Care Facilities Planning Act, N.J.S.A. 26:2H-18(d). On the other hand, the power and duty to determine charges made to the general public remain [*394] vested in the governing bodies of defendant hospitals. The rate-making process under the above act requires the rate of payment by Blue Cross to participating hospitals to be approved annually. The actual procedure is that in October or November of the preceding year each hospital prepares and submits its proposed operating budget for the coming calendar year to the Budget and Advisory Committee appointed by the Commissioner of Insurance. The Advisory Committee consists of three physicians, five hospital administrators, and four hospital trustees. The Committee is assisted in its review by the Budget Review Staff, a division of the Hospital Research and Educational Trust of New Jersey. The Health Care Facilities Planning Act requires the Commissioner of Health, in consultation with the Commissioner of Insurance, to determine and certify the costs of providing health care services based on reports prepared by the hospitals in accordance with a uniform system of cost accounting. N.J.S.A. 26:2H-18(c).

The Committee recommends to the Commissioner for his approval a tentative per diem reimbursement rate for the operating year for admissions to each hospital.

It is conceded by the hospitals and Blue Cross that in computing reimbursement [**588] rates by Blue Cross the Commissioners of Insurance and Health omit from consideration some of the costs necessary to the operation of hospitals (e.g., the cost of providing indigent care). As a result the rates hospitals charge others, including plaintiffs, is computed to permit the hospitals to recapture their omitted costs. The difference in rates is said to approximate 20%.

In a report published in 1974, this reimbursement system was roundly criticized as being controlled by the industry and not in the interests of the public. The Hospital Research and Educational Trust of New Jersey (“HRET”), referred to in the opinion, was a component of the New Jersey Hospital Association.

In response to this criticism, in the early part of January 1975, the Commissioner of Health issued guidelines to members of the DOH, for use in reviewing the budgets of all the acute care hospitals. The guidelines were known as the Standard Hospital Accounting and Rate Evaluation System (“SHARE”), a more complex rate setting system than the hospitals had been using up to that point in time. These guidelines were not adopted pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1, et seq. (hereinafter “APA”). Further, in January of 1975, the Commissioner of Health published proposed appeal rules, which were adopted and filed with the Secretary of State on March 12, 1975.

In response to the action of the Commissioner of Health, five hospitals (Monmouth Medical Center, Community Medical Center, Point Pleasant Hospital, Riverview Medical Center and Freehold Area Hospital) filed suit against the Commissioner of Health and the Commissioner of Insurance, as well as the Hospital Service Plan of New Jersey (Blue Cross). While this suit sought various forms of relief, the main focus of the complaint involved the failure of the DOH to have adopted the SHARE guidelines pursuant to the APA, the nature of the appeals process, and the delay in setting the rates for the hospitals.

continued on page 34
continued from page 33

As set forth in the litigation, the hospitals had submitted, pursuant to the pre-SHARE procedures, their budgets for 1975 in the late summer and fall of 1974. The decision to apply the new SHARE guidelines, after the year 1975 began, by its very nature created an issue for the hospitals, since the SHARE guidelines were not in effect at the time that the hospitals' 1975 budgets were prepared and submitted.

It was the initial position of the DOH that the proposed SHARE “guidelines” did not need the approval of the Health Care Administration Board (“HCAB”) and could be implemented solely by the adoption of the Commissioner of Health and the Commissioner of Insurance.

The only issue that the court decided, was that the guidelines were, in fact, regulations and that the Commissioner of Health had not followed the APA in adopting these “guidelines.” The court remanded the matter back to the Commissioner of Health, but did not rule upon any of the other issues in the litigation.

After some additional activity before the courts, the Attorney General issued a formal opinion on April 30, 1975, which stated that:

In the instant situation, the Appellate Division reviewed the 1975 guidelines in Monmouth Medical Center, et al v. State of New Jersey, et al, Docket No. A-2147-74, et seq., decided April 30, 1975 and opined:

We have no hesitancy in deciding that the guidelines issued were rules as the term is defined in N.J.S.A. 52:14B-2. The procedures are clearly established to implement the task of the Commissioners in carrying out their respective responsibilities under the provisions of N.J.S.A. 26:2H-18(c) and (d) and N.J.S.A. 17:48-7.

The court further concluded that the health care facilities should be sufficiently apprised in advance by proposed administrative regulations of the criteria used to determine the reasonableness of the reimbursement rates.

You are accordingly advised that in the event the 1975 guidelines are used to determine the reasonableness of the 1975 reimbursement rates, under N.J.S.A. 26:2H-18(d), these guidelines are administrative regulations subject to the approval of the HCAB and should be adopted in accordance with the Administrative Procedure Act.¹

In light of this Attorney General opinion, a meeting of the HCAB was convened. Prior to that meeting, there were significant discussions between the members of the HCAB and the various hospitals, Blue Cross as well as the representatives of the Commissioners of Health and Insurance. The role of the five hospitals involved in the litigation attacking the SHARE guidelines was now superseded by the New Jersey Hospital Association (“NJHA”). NJHA led the discussions as to the role to be played by the HCAB in adopting the SHARE “guidelines”.

As counsel to Monmouth Medical Center, I had been informed by the CEO of my client, Felix Pilla [who was also the father of Mark Pilla, who previously served as both the President of Community Medical Center as well as the Executive Vice President of Barnabas Health] that it appeared that the HCAB would vote not to adopt the SHARE guidelines by a one vote majority. The HCAB meeting was a very tense meeting, probably attended by every hospital administrator, executives of Blue Cross and the various governmental departments, as well as other third party payors. When the vote was taken, the guidelines were approved by one vote. It is interesting at this point in time, to look back at the fact that the public members (those not associated with the governmental agencies or the hospitals) voted not to approve the guidelines as regulations.

The two votes which made the adoption possible were the votes of Lloyd Wescott, who was on the Board of Hunterdon Medical Center and the vote of Monsignor Raymond Pollack, who was the Director of Hospitals for the Newark Archdiocese. To say there was disappointment on behalf of the hospitals would be an understatement in light of the effort, both “political” and legal, to force the matter before the HCAB.

As Felix Pilla opined after the meeting, “the bad news is that we will look back on SHARE as the good old days.”

The SHARE System was an attempt by the DOH, through regulations, to control the cost of health care to Blue Cross beneficiaries. This was done by redefining cost centers, comparing the cost being recorded by different hospitals in cost centers, and disallowing costs that were over and above the corridors permitted under SHARE for the various cost centers.

After the initial determination as to the allowable costs and initial meeting then a “final cost schedule” would be issued which was ultimately the subject of an administrative appeal. One must look at this as an attempt by the DOH to micromanage the activities of each hospital (with approximately 100 acute care hospitals in the State of New Jersey in existence at that time), even though SHARE was applicable only to the Blue Cross and Medicaid payors. One of the issues that SHARE did not take into consideration was the various management approaches to providing services, which resulted in costs “being out of line” in some cost centers, because they were significantly below the comparisons in other cost centers. Also, certain unique circumstances, particularly payor mix, were not addressed.

Two of the issues not addressed by the court then came into play. The first issue was the timeliness of the rates being set for the hospitals. As argued in the brief, on behalf of the hospitals,
the rates set for 1975 were not final in 1975.

Under SHARE, after the “informal discussions between the hospital and the DOH” if there was not an agreement, the hospital was entitled to take an administrative appeal. The initial administrative appeal was structured, so that the hearing panel would consist of eight experts in the health care field, who would be able to judge the reasonableness of the costs being incurred by the hospital in each one of the cost centers. The difficulty with this approach turned out to be that an appeal hearing for a hospital could run for days.

The first hospital to enter into the hearing process was Monmouth Medical Center and after two and one-half days of hearings, when Monmouth Medical Center returned for the afternoon session of the third day, the Assistant Commissioner, John Reiss, was the only person sitting where the panel had sat for the two and half days and not a single member of the panel was present. At that point, Monmouth Medical Center was informed that the panel had resigned and felt that it was impossible for that mechanism to work in light of the fact that almost all, if not all hospitals, had requested an appeal and that it appeared that the average appeal would run for a number of days. So while the court and the litigation never addressed the hearing process, pragmatically the hearing process proposed by the DOH was unworkable. The DOH then fell back on the normal hearing process laid out in the Administrative Procedure Act, which requires the appointment of a hearing officer. However, rather than referring the matters to the Office of Administrative Law, which would then assign one of its professional hearing officers, the DOH retained their own hearing officers for the initial appeals.

The use of hearing officers is important to note because the hearing officer approach that the DOH employed was to use a hearing officer who was a lawyer, not an expert in the health care field. The reality is that once the SHARE appeals were no longer heard by the experts on a hearing panel, the “lawyer hearing officer” more and more relied upon the expertise of the DOH witnesses, which were given considerable weight. By the time the original court challenge to SHARE reached the Appellate Division, the Appellate Division relied upon the legal principle of administrative deference and determined that the Appellate Division would defer to the administrative expertise of the Commissioner of Health.

The implementation of the SHARE system also demonstrated that the judicial appeal process was inadequate due to the time delay in the processing of appeals. As an example, a case ultimately decided by the Appellate Division in May of 1982 dealt with the rate appeals for the years 1975 for Passaic General Hospital, 1976 for Saddle Brook General Hospital and Millville General Hospital, 1977 for Millville General Hospital and Passaic General Hospital, 1978 for Millville General Hospital and Passaic General Hospital, 1979 for Millville General Hospital and Monmouth Medical Center, and 1977 for Monmouth Medical Center.

The complexity of the SHARE system and the fact that it was only applicable to the Medicaid and the Blue Cross payors led the DOH to obtain a waiver to create a single rate making system, not a single payor system. At this time, the State of New Jersey developed and tested a DRG system. While it had a few of the elements of the DRG system now used by the Medicare program, overall the Medicare DRG system is not the DRG system developed and implemented by the DOH in many of its aspects. The New Jersey DRG system was ultimately abandoned after litigation was brought by various third party payors against the DOH, even though the validity of New Jersey’s DRG system was upheld by the Court of Appeals for the Third Circuit.6

It makes sense to look back and see what can be learned and applied going forward. If one looks at the methodologies in use today, you have the largest payor, the Medicare system, unilaterally setting its payment rates without a complex rate making system, based on each hospital submitting its budget annually. And while those payment rates may fall into broad categories, they are not, as in New Jersey SHARE and subsequent New Jersey DRG systems, hospital-specific.

Today, the commercial third party payors, the labor unions, and other payors negotiate their payment rates with the hospitals, and, the complex rate setting system embodied by SHARE has been abandoned. The lesson learned is that the acute care hospital delivery system is a very complex system and cannot effectively be micromanaged by a state imposed payment system.

Endnotes

2The Center for the Analysis of Public Issues by R. Powell, entitled “Bureaucratic Malpractice”
3The SHARE regulatory system required hospitals to obtain outside expertise. This could be described as the full employment for accountants, consultants and lawyers.
Building an Integrated Population Health Data (iPHD) Project for New Jersey

by Natassia M. Rozario

Editor’s Note: This article was written prior to December 10, 2015, the date on which legislative proposals creating the iPHD Project (53220/A4790) were heard in committee and approved. The bills include minor amendments not reflected in this article.

New Jersey is at an exciting point in reforming its public health system to improve quality and reduce costs. The Integrated Population Health Data (iPHD) Project provides policymakers, researchers, Accountable Care Organizations, community groups, and other public support programs the tools they need to promote good care in New Jersey and generate cost-savings. By linking administrative datasets together, New Jersey can build upon the work its agencies, executive authorities, and legislature have already done to improve healthcare delivery continuously in the state.

Good care requires good data. As healthcare costs rise and patients and providers become increasingly frustrated with the system’s failures and inefficiencies, new and innovative solutions are urgently needed. The good news is that New Jersey is at an exciting time in its journey to improve the quality and efficiency of its healthcare system.

The Good Care Collaborative (GCC), a coalition of stakeholders from across the healthcare spectrum in New Jersey, proposes that the state establish the Integrated Population Health Data (iPHD) Project, which would integrate healthcare data already being collected from departments, agencies, and public support programs at the local, state, and federal levels with data already being collected on other services that are important to achieving good health (e.g., housing, homelessness, education, social security, transportation, employment, and criminal justice systems).

The iPHD Project has the potential to transform New Jersey’s healthcare delivery system. Patients, especially those facing complex medical and social needs and those incurring the highest costs, rely on multiple public systems and services (e.g., healthcare, criminal justice, and housing). These systems interact in complex ways. Reducing costs and improving outcomes, therefore, requires understanding forces both within and outside the health service sectors.

The approach is supported by research demonstrating that the conditions in which we live and work have an enormous impact on our health, long before we ever see a doctor. The journey to good health begins in our homes, in our schools and workplaces, in our playgrounds and parks, and in the air we breathe, the food we eat, and the water we drink. The more we see health this way, the more opportunities we have to improve it and save costs by preventing and treating medical conditions before they reach the point of expensive treatment. Linking different datasets that exist within agencies, departments, and public support programs is essential for a holistic understanding of the forces driving poor health. But, unfortunately, multiple laws and bureaucratic hurdles impede data linkage. A well-structured and governed iPHD Project would help overcome these challenges and provide a rich resource for identifying ways to improve population health and make government programs more efficient and effective.

The Center for State Health Policy (CSHP) at Rutgers University’s Institute for Health, Health Care Policy and Aging Research would house the iPHD Project. In New Jersey, CSHP has already demonstrated the power of data linkage and analysis to deepen our understanding of avoidable hospital use and cost. By linking various datasets (e.g., all-payer hospital billing records, charity care data, death records, and census data), CSHP has identified the significant role that behavioral health conditions play in driving costs, the persistence of hospital use among high-users over time, the extent to which care of high-users is fragmented across multiple hospitals, and the patients who are at the greatest risk of fragmented care. Without the ability to link disparate administrative datasets, CSHP would not have been able to study these issues and arrive at its findings. The iPHD Project would create greater opportunities for this type of valuable research in a cost-effective and efficient manner.
The iPHD Project in a nutshell

**What is the iPHD Project?** The iPHD Project is an integrated data system linking health data with other social administrative datasets while safeguarding the privacy and security of the data. The iPHD Project provides the infrastructure to link health data with social data on a project by project basis, allowing administrative datasets to be added as they are needed to address policy development, research, and evaluation priorities.

**What is its purpose?** To facilitate research and the development of the most effective means for improving the health, safety, security, and well-being of New Jersey residents and the overall cost-efficiency of government programs.

**Why do we need it?** The iPHD Project has the potential to transform New Jersey’s healthcare delivery system. Patients, especially those facing complex medical and social needs and those with the highest costs, rely on multiple systems and services (e.g., healthcare, criminal justice, housing). These systems interact in complex ways. Reducing healthcare costs and improving health outcomes, therefore, requires understanding forces within and outside the health service sectors. By providing a more holistic understanding of health, the iPHD Project would help the state achieve its Healthy 2020 goals, ensure the success of the Medicaid ACO Demonstration Project, and promote population health generally.

**What would it cost?** The iPHD Project would not impose additional burdens or significant costs upon the state. Many departments, agencies, and public support programs at the local, state, and federal level already collect large amounts of data to administer their programs. The departments, agencies, and public support programs, however, lack the infrastructure and resources to link the data together to provide a fuller picture of what factors are affecting New Jerseyans’ health. By linking disparate datasets, the iPHD Project would allow these entities to leverage their current data collection efforts without additional burdens. Similar integrated datasets in other states have been associated with saving money and improving efficiencies in the state.

**How will it safeguard privacy and security?** The iPHD Project governing board would have a formal process to review data requests made by administrators, certified Medicaid ACOs, and researchers to ensure the ethical and appropriate use of the data and that these requests meet rigorous security and privacy standards.

The table below lists other potential research initiatives the iPHD Project would support:

<table>
<thead>
<tr>
<th>Project</th>
<th>Examples of data linkage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study variations in the quality and outcomes of cancer care and identify best practices</td>
<td>• Link Medicaid, Medicare, or other claims data to the New Jersey Cancer Registry</td>
</tr>
<tr>
<td>Monitor and improve transitions to the community among vulnerable and at-risk populations</td>
<td>• Link jail/prison health service data to Medicaid data • Link homeless services data to Medicaid data</td>
</tr>
<tr>
<td>Evaluate the efficiency and effectiveness of ongoing public health programs</td>
<td>• Link jail/prison health service data to Medicaid data • Link data on Housing First program participation to community addiction services, hospital emergency department and inpatient data, workforce data, and education data</td>
</tr>
</tbody>
</table>

**A multitude of benefits.** As described above, the iPHD Project would help serve as a catalyst for population health research. It would both support state commissioned studies and also attract outside research funding and talent to the state. This research, in turn, would advance population health in multiple ways. For example, it would:

- Help the state achieve many of its Healthy New Jersey 2020 goals, including:
  - Identifying statewide health improvement priorities;
  - Increasing public awareness and understanding of the determinants of health, disease, and disability and the opportunities for progress;
  - Providing measurable objectives and goals that are applicable at the state and local levels;
  - Engaging multiple sectors to take actions to strengthen policies and improve practices that are driven by the best available evidence and knowledge;
  - Identifying critical research, evaluation, and data collection needs;
  - Highlighting opportunities to improve health care efficiency.
- Promote the success of the NJ Medicaid ACO Demonstration Project by revealing new opportunities to improve the quality of health and reduce costs;
- Improve coordination among state agencies and their affiliated providers;
- Create a data rich environment allowing policymakers to make evidence-based decisions;
- Support agency, department, and public support program administrators with meeting the complex and interconnected needs of their client populations efficiently and effectively.
continued from page 37

As a result of improving population health, the iPHD Project would yield a constellation of other positive spillover effects. Research from across the globe demonstrates that good health leads to increased productivity, reduced absenteeism, and higher educational attainment; all of which have a positive impact on the education system, the business community, and the economy at large.

Many benefits without additional burdens. The iPHD Project would not impose additional burdens or significant costs upon the state. Many departments, agencies, and public support programs, in the state of New Jersey already collect large amounts of data to administer their programs. The departments, agencies, and public support programs, however, lack the infrastructure and resources to link the data together to provide a fuller picture of what factors are affecting New Jerseyans’ health. By linking disparate datasets, the iPHD Project would allow these entities to leverage their current data collection efforts without additional burdens. Similar integrated datasets in other states have been associated with saving money and improving efficiencies rather than imposing additional costs.

How do we build the iPHD Project?

House the data. CSHP would house and link key state datasets to enable valuable analyses by authorized entities, including policymakers, researchers, certified Medicaid ACOs, community groups, and other public support programs. CSHP already has established relationships with key state agencies and has experience accessing and linking state administrative data. For example, the NJ Medicaid ACO Demonstration Project calls on CSHP to provide technical assistance for the implementation and evaluation of gainsharing plans submitted by coalitions seeking state certification to become Medicaid ACOs. CSHP is also responsible for evaluating New Jersey’s Comprehensive Medicaid Waiver Demonstration whereby it receives comprehensive Medicaid enrollment data, fee-for-service claims data, and managed care encounter data to conduct data analyses. CSHP was also commissioned to use Medicaid data to help inform recommendations on improving care and reducing costs for the top 1 percent of Medicaid beneficiaries who account for a disproportionate share of program spending. Most recently, CSHP was awarded a federal State Innovation Model Design Award to help the state assess and plan population health and delivery system improvements, again drawing on analysis of Medicaid administrative data.

By collecting data for the iPHD Project, CSHP would have enhanced capacity to serve in its current role as technical advisor to the state and be able offer more robust and effective solutions for health improvement and cost savings.

Identify the data to be linked as needed. The iPHD Project would have expandable scope, allowing administrative datasets to be added as they are needed to address policy development, research, and evaluation priorities. The iPHD Project would start on a small scale, accessing data only on a project by project basis.

Create a governing structure. Oversight of the operations of the iPHD Project would be vested in the governing board, which would have a formal process for reviewing projects. The governing board would deliberate the plausibility and merits of each proposal, and either approve or reject the projects. It would be comprised of ten members (nine voting; one non-voting). Four of these members would be public members appointed by the Governor with advice and consent of the Senate and would include:

- An individual representing an organization capable of advocating on behalf of persons whose social services data may be received, maintained, or transmitted by the iPHD Project;
- An individual with legal expertise and interest in protecting the privacy of individually identifiable information;
- An individual with technical expertise and interest in the creation of large data systems and data security;
- An individual with experience as a researcher and with service on an Institutional Review Board (IRB) charged with oversight responsibility for ensuring compliance with standards defining the ethical conduct of research.

The five remaining voting members would be ex-officio members representing the Secretary of the Department of State; the Commissioner of the Department of Human Services; the Commissioner of the Department of Health; the Department of Law & Public Safety, office of Attorney General; and the Chief Information Officer of Rutgers University. The Director of the Rutgers Center for State Health Policy would serve as an ex-officio non-voting member.

The governing board would be charged with ensuring that the iPHD Project receive, maintain, and transmit only data that is appropriate to meet its legislative purpose. In addition, the governing board would facilitate executing any needed data use agreements (DUAs) or business associate agreements (BAAs) in compliance with all applicable privacy and security standards.

The governing board would adopt policies and procedures for the efficient and transparent operation of the iPHD Project, including) privacy and security policies complying with the applicable federal and state privacy and security statutes and regulations (e.g., HIPAA); and 2) data access policies and procedures allowing access by an agency, department, or third party, including research organization, certified Medicaid ACOs, and other public support programs, only when such
request meets the standards in the data access policies and procedures approved by the Governing Board.

Each year, the governing board would publish an annual report that identifies the sources and types of data received and maintained by the iPHD Project over the prior twelve months; describes IRB-approved disclosure of data of data sets by the iPHD Project; lists all publications and reports that have been published based on iPHD Project data; and includes any other information deemed appropriate by the Governing Board.

**Protecting privacy and security.** Protecting the privacy and security of the data in the iPHD Project is paramount. CSHP would use state-of-the-art safeguards, which are compliant with legal and ethical standards at the federal, state, and local levels. These mechanisms would mitigate the risk of privacy and security breaches.

**Ensuring ethical and appropriate use of data.** No research using the iPHD Project data would proceed without the approval of a federally authorized, independent IRB. Further, the governing board, data-system administrators, and outside researchers would be required to follow ethical protocols, as outlined in local, state, and federal regulations, to ensure ethical and appropriate use of data maintained in the iPHD Project. Ethical and appropriate use entails not only protecting the security and confidentiality of data, but also requires that the researcher: 1) has the skills to organize and handle the data; 2) understands the limits of the data; and 3) and interprets the findings applying adequate information. The data would be used only for research in accordance with the legislation.

**Creating streamlined processes.** The iPHD Project governing board would establish standardized application and review procedures, which would improve efficiency in the process for reviewing applications for authorized use of data.

The iPHD Project is designed to make it easier for New Jersey state agencies and outside researchers to gain authorized access to integrated datasets, and it would not create new hurdles for those interested in using integrated data. If state agencies already have data sharing agreements in place that meet their needs, they will not be required to do anything differently. Agencies also are not required to share data exclusively through the iPHD Project.

**Let’s consider an example:**

**How the iPHD Project works**

You are a member of a research team working closely with the state to promote and evaluate state health policies. The Department of Human Services (DHS) is interested in exploring the linkages between housing and health. DHS asks your research team to evaluate housing projects targeting the chronically homeless who also heavily rely upon the hospital system. DHS is specifically interested in questions on the impact of new supportive housing programs on hospital utilization, Medicaid costs, and total public spending.

Your team has already received approval from your University’s IRB to conduct this research project, but is now having trouble accessing the relevant health and social data sets. Your team decides to submit a proposal to the iPHD Project governing board, requesting the linkage of health data with other social services data. Your proposal clearly delineates how such linkage will advance population health research and good public health policies in the state.

The iPHD governing board convenes and proceeds with a formal process deliberating the feasibility and merits of your proposal in accordance with the purpose of the iPHD. The iPHD governing board approves the project as the proposal clearly delineates how such research seeks to improve public health, safety, security, and wellbeing of New Jersey residents as well as to improve the overall cost-efficiency of government assistance programs.

Upon approval, the governing board facilitates the development of any necessary data use agreements or business associate agreements between state agencies contributing data and the data users in compliance with all applicable privacy and security standards. The governing board does not allow data to be moved into the iPHD Project until the state agencies are satisfied that applicable legal standards have been met.

To link and prepare the data, only trained, designated Rutgers CSHP staff have access to the data needed to execute linkages. To protect the data, this select staff use state-of-the-art privacy and security safeguards, which are compliant with legal and ethical standards at the federal, state, and local levels. These mechanisms mitigate the risk of privacy and security breaches. Once the data is cleaned and linked, CSHP staff strip all personal identifiers from the linked dataset and then send the linked dataset, in accordance with iPHD Project policy and procedures, compliance with all applicable data use and business associate agreements, and adherence to approved IRB protocols, to your team, which can now analyze the data.

In its annual report, the iPHD Project governing board publishes a brief summary of your research project, explains the purpose of your project, which datasets were used for analysis, and any research publications that have resulted from your analysis.

**Similar Integrated Data Projects**

Throughout the country, integrated data systems (IDS) similar to the iPHD Project have been created to improve public programs and social services. These programs have taken their cues from some of the most successful companies and organizations in the world, which have leveraged the power of integrated data sets to design products and services to better serve
customers and constituents. The following examples showcase the power of integrated data to bring together diverse actors, spark innovative and evidence-based projects, and improve quality and efficiency of programs.

**Washington State.** The Washington State Department of Social and Health Services manages the Integrated Client Data Base (ICDB).\(^3\) Compliant with HIPAA and strict confidentiality standards to protect personal client information, the ICDB links various social and health datasets. The database has streamlined the department’s capacity to conduct research aiming to enhance service delivery and policy outcomes across the state and has also saved money and improved lives. State agencies and qualified external entities are able to access this information to conduct rigorous policy analysis, which has helped the state identify whether programs are working. Through the ICDB, the Department’s Research & Data Analysis Division has produced over 350 reports on a wide spectrum of issues, including behavioral health and substance abuse, housing, education, employment, and foster care. These reports have bolstered the state’s ability to efficiently analyze outcomes, costs, and needs of government-funded health and social services and has created a robust policy laboratory. For example, one seminal report\(^6\) evaluated the state expansion of treatment for mental and substance and abuse disorders, which showed an impressive return on investment. Under conservative estimates, the evaluation demonstrated a return on investment of two dollars saved in medical and nursing facility costs for every dollar invested in the first four years of implementation.

**South Carolina.** The State of South Carolina Health and Demographic Section runs an integrated database with the tag line “We make government better by turning data into information and information into knowledge.”\(^7\) Through their IDS, the Health and Demographics Section is able to 1) receive, process, distribute, and interpret health, demographic, and census data statewide; 2) develop GIS (small-area mapping) infrastructure enabling users to obtain health, socio-economic and demographic analysis for planning, intervention and evaluation of programs; 3) educate policy makers and other data users about the availability and appropriate use of information; and 4) establish collaborative partnerships with agencies and research groups to conduct studies research projects related to health and socio-economic issues in South Carolina. With the ability to track patients over time, their IDS makes it easier to calculate readmission rates, hospital inpatient use, and emergency room visits, disaggregated by county of residence, age, race, and gender group.

**Rhode Island.** The State of Rhode Island has established a Data Hub that collects administrative data from state agencies and links data together to produce high quality information for social science researchers and program administrators.\(^8\) In addition to linking data sets for administrators and researchers, the Data Hub creates “Data Stories,” illustrating the value that linking data can produce. These Data Stories have focused on such topics as substance abuse, at-risk youths, and chronic absenteeism. One Data Story highlighted the educational costs of housing problems in the state of Rhode Island,\(^9\) illustrating how unhealthy housing contributed to increased absenteeism, a higher probability of repeating a grade, a higher likelihood of needing special education, and poorer test results. All of which not only impose strain upon students and their families, but also stress on the state’s fiscal wellbeing.

**New York City.** The City of New York has established an integrated database under The Center for Innovation through Data Intelligence (CIDI), which is a research/policy center located in the Office of the Mayor of the City of New York.\(^10\) The vision of CIDI is “to make data come alive to inspire change.” CIDI conducts citywide interagency research to identify areas of service need in the City, including child welfare, public assistance, juvenile delinquency, homelessness and education. CIDI has helped identify and analyze utilization patterns of programs and services; program costs and benefits; overlap in programs and services; linkages within and among systems; entry points into particular systems; and geographic distributions in services, including demand “hot spots.” For example, CIDI recently evaluated a supportive housing program for at-risk youth in NYC.\(^11\) Relying upon administrative data from different agencies, the study compared outcomes for youth enrolled in the supportive housing program with those youth who applied and were eligible, but ultimately not placed in the program. Controlling for other factors, the analysis found that program participants were 36 percent less likely to have a stay in the single adult shelter system and 55 percent less likely to go to jail during this time period.\(^12\)

In addition to the research agenda, CIDI provides analytic support for the Children’s Cabinet and Immigrant Health Task Force.\(^13\)

**Maryland.** With the leadership of its Governor, the State of Maryland established, through legislation,\(^14\) the Maryland Longitudinal Data System Center, which links education with workforce data for every student in the state to provide a clearer picture of student performance and their preparation for higher education and the workforce.\(^15\) The System is established jointly by the State Department of Education, the Department of Labor, Licensing, and Regulation, the Maryland Higher Educa-
Dade County criminal justice system. This study identified behavioral health services utilization and incarceration in the Miami-judge has worked with FMHI to analyze patterns of behavioral health, social and corrections services. ALP has helped Linkages Project (ALP) links data on publically funded health, in the county of Los Angeles, the Adult tion Commission, the University System of Maryland, Morgan State University, and St. Mary’s College of Maryland.

Los Angeles County. In the county of Los Angeles, the Adult Linkages Project (ALP) links data on publically funded health, mental health, social and corrections services. ALP has helped restructure the Los Angeles County General Relief Program—a cash assistance program for indigent adults. General Relief participants frequently need more than just cash assistance. Many experience homelessness, have disabilities, or face other challenges requiring housing and additional forms of assistance. Recognizing this complex nexus, the Los Angeles County’s Homeless Preventive Initiative partnered with ALP to monitor and analyze the participants use of various services, including health, social, and law enforcement. In one pilot project, they found that providing homeless participants with rent subsidies and help accessing essential supportive services reduced homelessness, increased employment, and increased SSI approval of rates, leading to significant cost-savings of $11 million for pilot participants over two years.

University of South Florida. At the University of South Florida, the Florida Mental Health Institute (FMHI) relies on its integrated database to study and promote several service system reforms for people with mental illness. A Miami judge has worked with FMHI to analyze patterns of behavioral health services utilization and incarceration in the Miami-Dade County criminal justice system. This study identified a group of mentally ill individuals who were “heavy-users” of behavioral health services and cycled frequently through the criminal justice system. Many of these individuals were unable to access care in the community. Left with no choice, they often accessed care through the most inefficient and most expensive points of entry including emergency rooms, acute crisis services, and ultimately the juvenile and criminal justice systems. As a result of this analysis, Miami-Dade County is creating a sentencing alternative for those individuals in the heavy-user group who have committed minor crimes. These individuals will begin in a higher-security area, but eventually will move to a different part of the building for treatment to encourage their re-entry and reintegration back into society and to prevent recidivism.

Federal Agencies. The Department of Housing and Urban Development (HUD) has partnered with the Department of Health and Human Services (HHS) to match HUD administrative data with Center for Medicare & Medicaid data. The linked data will improve understanding of how senior citizens live in publically subsidized housing and whether supportive housing interventions will affect their health care utilization patterns.

About the Good Care Collaborative (GCC)

Formed in 2013, the GCC is a diverse, statewide coalition of consumer advocates, providers, payers, and policy makers. It seeks to help transform New Jersey’s Medicaid system into a national model for delivering good care efficiently for every patient, every day.

About the Author

Natassia Rozario is the Associate Counsel & Associate Director of Policy & Engagement at the Camden Coalition.

Footnotes

3 Hempstead, K., DeLa, D., Cantor, J. C., Nguyen, T., & Brenner, J. (2014). The Fragmentation of Hospital Use Among a Cohort of High Utilizers: Implications for Emerging Care Coordination Strategies for Patients With Multiple Chronic Conditions. Medical care, 52, S67-S74.
4 Ibid.
7 AISP Network Site, State of South Carolina, http://www.aisp.upenn.edu/network-site/
8 AISP Network Site, Rhode Island, http://www.aisp.upenn.edu/network-site/providence-plan/
12 Ibid.
17 Supreme Court of Florida (2007). Report on Constructing a Competent Criminal Justice, Mental Health and Substance Abuse Treatment Program.
The ROI for Using Integrative Health Modalities as an Adjunct to Conventional Care: A Case Study

by Ruthann Russo, PhD, JD, MPH, Lac

At the age of 18, Jonathan was diagnosed with a generalized epilepsy disorder that resulted in uncontrollable grand mal seizures. Jonathan was treated by world-class epileptologists and neurologists using combinations of 3 or 4 anti-epileptic drugs and 2 or 3 additional drugs to manage the side effects of the complex medication regimen. Still, Jonathan experienced seizures, sometimes several per month which generally resulted in a trip to the ER with multiple x-rays and CT-scans to rule out internal damage from the trauma of the seizure. Some visits to the ER required admission to the hospital, generally for a 1 – 2 day stay. The CDC reports that epilepsy accounts for $15.5 billion in direct costs (medical) and indirect costs (lost or reduced earnings and productivity) each year. About 1 out of every 26 people will develop epilepsy at some point in their lives.

After 3 years of unsuccessful management of seizures, Jonathan’s epileptologist at a large Academic Medical Center recommended that he “view this condition as a life style issue” and “take control of his care”. Jonathan and his mother were dumbfounded by this statement at first, but wanted to understand what his doctor meant by this recommendation. The physician pulled out a book that addressed the use of integrative health modalities (IHMs) for epilepsy and recommended Jonathan read through the book and try any or all of the IHMs that were considered safe.1 He further went on to state that he planned to continue treatment of Jonathan’s epilepsy with drugs, Jonathan and his family had a responsibility to do what they could to manage both his epilepsy and their response to it. He explained that IHMs are patient-driven approaches to health that address the full range of physical, emotional, mental, social, and spiritual influences that impact an individual.2 Then he pointed out examples of IHMs in the book such as yoga, meditation, relaxation response, and biofeedback. Neither Jonathan nor his mother knew anything about these IHMs, but it piqued their curiosity. Mother and son left the physician’s office, book in hand and new hope in their hearts.

Over the course of the next 2 months, Jonathan and his family transformed their lives based on the content of the book provided to them by his epileptologist. Jonathan began a serious practice of yoga that eventually led him to study as a yoga teacher. He and his mother attended the Mindfulness Based Stress Reduction (MBSR) program at the University of Massachusetts Medical Center in Worcester, MA. The family eliminated gluten and reduced sugar intake in their diet. Jonathan also began receiving weekly acupuncture treatments from a local licensed acupuncturist and consulted with a certified biofeedback therapist. Eventually, Jonathan was able to reduce his acupuncture visits to one visit every 1 to 2 months. And, his biofeedback therapist trained Jonathan in the use of the HeartMath biofeedback APP allowing him to practice biofeedback without the assistance of his therapist after just 6 visits.

Jonathan experienced only one seizure approximately 3 months after he began using IHMs. Five years later, after continuing yoga, mindfulness meditation, HeartMath biofeedback, and a diet free of gluten and most sugars, Jonathan remained seizure free. Interestingly, the evidence-base has shown that IHMs calm the nervous and endocrine systems [by increasing the production of certain hormones and chemicals such endorphins, and decreasing others such as cortisol], allow the creation of new neural networks and growth of the frontal lobe of the brain, and relax smooth muscles in both the gastrointestinal and cardiovascular systems. These mechanism, it turns out, are key to managing stress and preventing or controlling most chronic disease [For a detailed listing of the evidence base and research studies to support these claims see Russo, Stitcher, & Diener article, hfm magazine, November, 2015].

In addition to the cessation of Jonathan’s seizures, his mother was able to return to work and the level of stress in the household was significantly reduced for all. Most importantly, Jonathan’s visits to the ER fell from an average of 10 per year to 0, his inpatient stays were reduced from an average of 6 per
year to 0, his physician visits fell from an average of 24 per year to 2, and his medications were reduced from 4 to 7 a day to 1 per day. Jonathan’s story is one of many for individuals who have found IHMs, used as an adjunct to conventional treatment, improves the quality of their lives, their families’ lives, and eliminates or controls the symptoms of their disease.

A conventional medicine practitioner may point to the following claims as reasons for why these practices should not be relied upon as evidence-based medical treatment. First, Jonathan tried several interventions all at once, so there is no way to know whether yoga, meditation, biofeedback, or diet alone, or some combination was responsible for controlling the seizures. Second, Jonathan’s is a case study only and cannot be applied to the population in general. Finally, it is possible that even after 3 years of uncontrollable seizures using conventional interventions, the seizures might have stopped even without Jonathan’s IHM practices.

Although there is no way to prove or disprove this last claim, in Jonathan’s case, the outcomes of using IHMs speak for themselves: improved quality of life for the patient and his family, absence of disease, a significant decrease in healthcare costs for the family, the father’s employer, and society. Jonathan’s neurologist, who recommended the practices as a way for Jonathon to take control of his health, may have identified the most significant outcome of IHMs: patient engagement. Additionally, the per patient savings in healthcare costs can be estimated to be between $60,000 and $95,000 per year. [The range is based upon the number of diagnostic tests required after each episode and whether ambulatory or inpatient EEG monitoring was required]. Contrast this with the costs to train Jonathan and some of his family members in the following IHMs: Yoga classes are offered at the local gym where Jonathan’s family had a membership; training in MBSR cost $500; the first year of acupuncture treatment cost $1,200 and each subsequent year cost fell to $300; and, the first year of biofeedback therapy cost $750 and an initial investment of $125 in HeartMath equipment with subsequent biofeedback costs dropping to zero. Total investment from Jonathan’s family in IHM during year 1 was $2,575 [about $500 more than his previous annual health plan copayments] with continuing annual costs being $300. Few if any of these modalities or training methods are currently covered by health plans.

Although Jonathon’s family was able to bear the economic burden of investing in these IHMs for their son, not all families have this capability. In some cities, states, and healthcare systems, less expensive or even free options exist. Take for example, the NYU-Langone Medical Center where I practiced along with 8 other integrative clinicians, in the department of Integrative Health Programs (DIHP). At NYU-Langone, the DIHP is included as an operational line item in the hospital’s budget, justified by the outcomes the program produces. Practitioners provide meditation, yoga, guided imagery, hypnosis, and relaxation response training (among other modalities) to hospital inpatients and their families. Outcomes, which are still being refined, include increased patient satisfaction scores, decreased length of stay, decreased readmission rates, decreased pain levels and use of opiate drugs. Healthcare systems have the ability to apply these practices at the population health level with benefits flowing directly to the patient and patient families and indirectly to the healthcare system and surrounding community. The use of IHMs can healthcare systems meet some PPACA and CHNA requirements while creating unique opportunities for ACO contributions. Still, there are hurdles to be cleared before these programs can be accepted, created, and adopted.

Education of healthcare practitioners and patients. Few practitioners and patients are aware of integrative modalities, their training requirements or the benefits they generate. Healthcare systems that are the most successful with IHM implementation, such as Cleveland Clinic and Beth Israel Medical Center, provide ongoing education to healthcare practitioners, patients and the community about IHMs and experiencing their benefits. Identification of a physician champion can increase both exposure and acceptance of IHM modalities within the system.

Sustainability of the practices. It can be hypothesized that the severity of his condition motivated Jonathon to sustain his IHM practices over several years. However, not all patients with chronic conditions are faced with a life-threatening condition such as Jonathan. Strategies for sustainability of IHMs include training within a group of peers and using self-efficacy techniques. Group training can make the process seem less threatening to a patient and decrease costs for the healthcare system. The creation of online discussion groups can also be used to encourage continued practice. Finally, the use of a structure to deliver IHMs, like those created by Stanford University’s Center for Compassion and its Chronic Disease Self-Management program can increase patient compliance with and sustainability of IHM practices.

Awareness that IHMs are evidence-based. The numbers of peer reviewed journal articles, meta-analyses, and Cochrane Systematic Reviews for each type of IHM is in the thousands and, fueled by NIH grants, continues to grow exponentially each year. In addition, professional medical associations such as the American College of Physicians and organizations such as the Academic Consortium for Integrative Medicine and Health have published references on the use of evidence-based IHMs for physicians and other healthcare practitioners.3

Data collection and outcomes measures. The continued collection of data around both patient response and satisfaction with IHMs must be refined. Furthermore, the economic cost...
benefit of these modalities should be collected and shared publicly to ensure continued growth and use of IHMs as an adjunct to conventional medicine treatments and therapies.

Conclusion and recommendations. In Jonathan’s case, he suffered for 3 years with uncontrolled seizures until his neurologist spoke to him about what Jonathan could do to help himself. What if IHMs were used as an initial intervention – instead of the last resort – along with conventional medicine, to manage patients from a holistic perspective? The PPACA provisions clearly place the patient as the driver of his or her care, envision the patient taking increased responsibility for his health and wellness, ultimately resulting in increased quality of care and decreased costs. IHMs appear to be a means to achieving that end.

NOTE: This case study is one of many examples of the impact of IHMs on patients with chronic conditions. For a quantitative population health, evidence-based analysis of the adjunctive use of integrative health modalities in healthcare systems, see the November, 2015 hfm magazine article by Russo, Diener, & Stitcher entitled The Low Risk, High Return of Integrative Health Services.

About the author
Ruthann is a visiting faculty member in public health at The College of New Jersey, an adjunct faculty member in the College of Integrative Medicine and Health Sciences at Saybrook University and a founding consultant with the Medala Group. Ruthann can be reached at rrusor@tcnj.edu.

Endnotes
## Editorial Calendar and Ad Rates 2016

Published 4x a year, *Garden State Focus* is the premier publication reaching over 1,200 Healthcare Industry influencers and decision makers behind New Jersey’s prominent hospitals and healthcare systems. Advertisers also receive complimentary website presence on HFMANJ.org with 2,500 impressions monthly.

### Frequency rates displayed below. Advertise in more issues for maximum exposure and better value!

<table>
<thead>
<tr>
<th>Issue / Deadline</th>
<th>Black &amp; White</th>
<th>Color</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Per issue/ Total</td>
<td>Per issue/ Total</td>
</tr>
<tr>
<td></td>
<td>1x</td>
<td>2x (10% off)</td>
</tr>
<tr>
<td>Full Page</td>
<td>$ 675</td>
<td>$ 607 / $ 1,214</td>
</tr>
<tr>
<td>Half Page</td>
<td>$ 450</td>
<td>$ 405 / $ 810</td>
</tr>
<tr>
<td>Quarter Page</td>
<td>$ 275</td>
<td>$ 247 / $ 494</td>
</tr>
<tr>
<td>Back Cover – Full Page</td>
<td>$ 1,450</td>
<td>$ 1,305 / $ 2,610</td>
</tr>
<tr>
<td>Inside Front Cover – Full Page</td>
<td>$ 1,350</td>
<td>$ 1,215 / $ 2,430</td>
</tr>
<tr>
<td>Inside Back Cover – Full Page</td>
<td>$ 1,350</td>
<td>$ 1,215 / $ 2,430</td>
</tr>
<tr>
<td>First Inside Ad – Full Page</td>
<td>$ 1,300</td>
<td>$ 1,170 / $ 2,340</td>
</tr>
<tr>
<td>Full Page</td>
<td>$ 1,100</td>
<td>$ 990 / $ 1,980</td>
</tr>
<tr>
<td>Half Page</td>
<td>$ 800</td>
<td>$ 720 / $ 1,440</td>
</tr>
</tbody>
</table>

*Special ANNUAL INSTITUTE Issue*

**Bonus Distribution at HFMA-NJ’s 40th Annual Institute in Atlantic City, October 5-7, 2016!**

Spotlighting issues and topics shared by the Institute presenters.

**To advertise, please contact Laura Hess :: 888-652-4362 :: NJHFMA@aol.com**
Is your hospital one of the 2,610* receiving reduced Medicare payments in 2015 due to excess readmissions?

*Source: Kaiser Health News

Take steps now to minimize your long term exposure to readmissions penalties.

BESLER Consulting expertly blends clinical and demographic data with your QualityNet hospital-specific report, furnishing you with a more detailed picture of provider readmissions and underlying causes affecting your unique population. BESLER can also assist you in developing strategies that can ultimately decrease readmissions so you can avoid Medicare penalties.

To watch a short video explaining how new analytics can help you understand readmissions at your specific facility, visit www.besler.com/readmissions.