

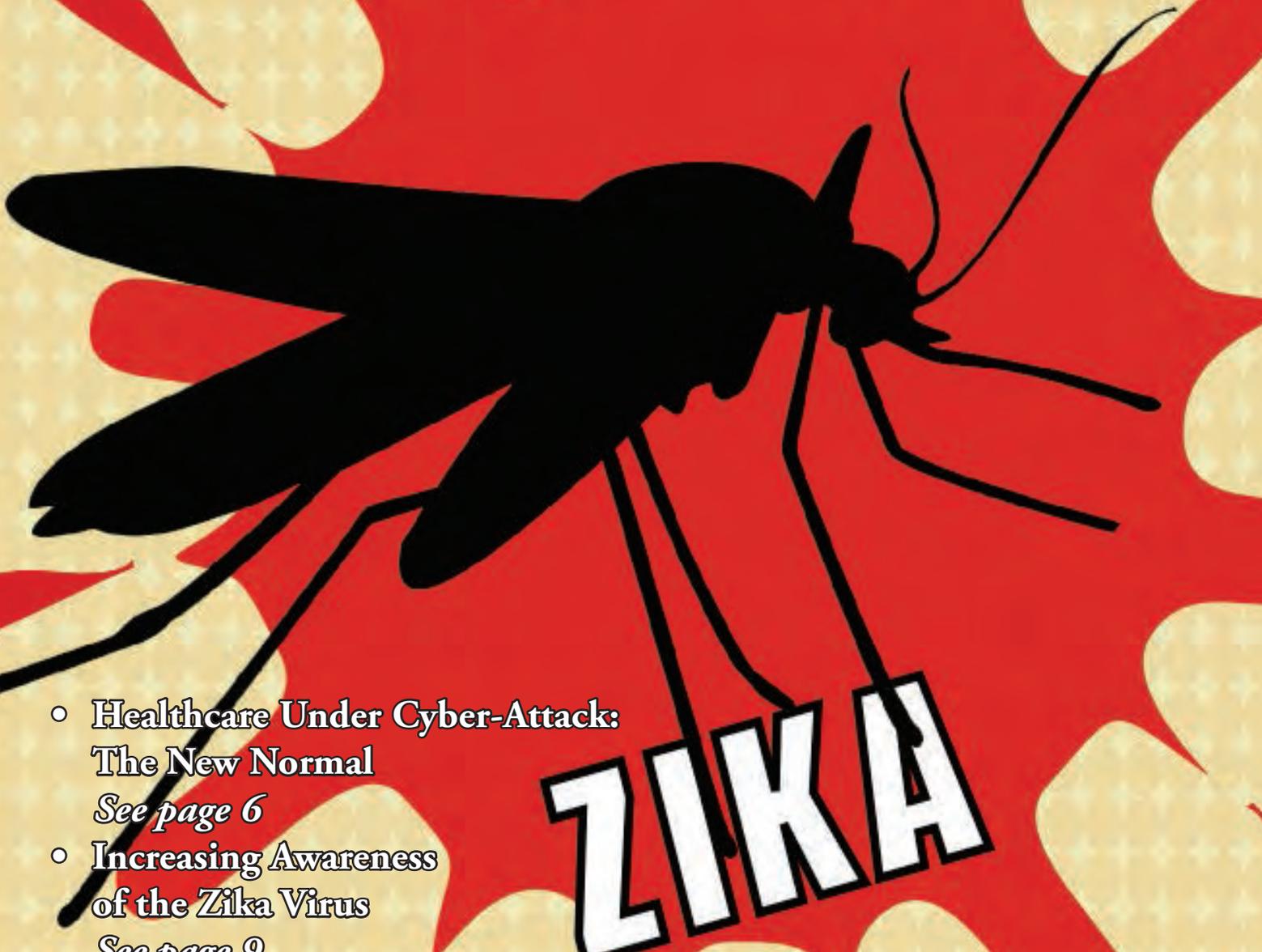


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OBJECTIVE

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

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Incoming President

Happy Summer Everyone!

I am honored and privileged to be taking over the helm of the New Jersey chapter of HFMA. It has been great working with Heather Weber for the last year as her President Elect. She has been a great teacher, and under her direction the New Jersey Chapter had a fantastic year!

We are so fortunate to have so many engaged members in our chapter but there is always room for more participation, after all it's one of the things that makes the New Jersey Chapter stand out. If you are new to the Chapter, take a look at page 15, Who's Who in Chapter Committees; it's a great place to start your journey in our chapter. We offer many monthly meetings on many select areas of Healthcare Finance. The best part of these meetings for me was always the round table discussion. The discussions are not only a great place to solve current issues you might be having, but also a great place to meet colleagues and make new friends. Many of these meetings take place via conference call and there is no charge to join the call. Bring a friend and share the value of HFMA! If you're not a newbie be sure to welcome the new members to your meetings.

The one area we and many of our sister chapters had difficulty with this year was our membership numbers. With the consolidation of the Healthcare arena, it is only natural that our membership might drop. We have great plans to engage other areas of the Healthcare Finance arena in the coming year. We have had a longstanding partnership with HIMSS and have reached out to MGMA; additionally, our Membership committee is working on some special events to attract new careerists. So, yes, I am very excited to be at the helm. If all goes well, perhaps our membership will grow in a time when that is not the trend.

In closing, I want to thank our all of the Committee Chairs, Co-chairs, Board Members and Sponsors. What's the saying? It takes a village? Without all of us working as a team, we could not succeed. The chapter is here for you, the member. Please reach out to me or one of the other officers or board members with your comments. We are always looking to improve the chapter and provide more for our members. We thank you for your support.

Dan Willis



Dan Willis

thrive

Outgoing President

Hello everyone,

It seems like only yesterday I was writing my first president's letter for the FOCUS, and now it is time for me to write my last. When I look back over the past year, I am very proud of the accomplishments the New Jersey chapter had this year.

The chapter provided over 19,571 hours of education during the year and we increased our certified members. 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. On November 12, 2015, we held a 60th Anniversary Event which honored our past presidents and celebrated their service and dedication, which has made the NJ Chapter what it is today. There were 12 past presidents that were in attendance. There is a lot for this chapter to be proud of, and since 1999 our chapter had received 72 awards from National. I am excited to say we were able to add to this list of honors this year with 4 chapter Yerger awards, 2 multi-chapter Yerger awards, and the Sister Mary Gerald Bronze Award for Education. There were many new networking events held during the year: "It's A Shore Thing!" happy hour on the boardwalk on the Jersey Shore; "Tap Into Fall" happy hour, and "Strike It Up!" bowling social. Plus the golf outing was a success and so was the golf clinic, which was a new option this year and had 30 participants. The Women's event also increased attendance and was a great success with 110 attendees which was a 50% increase over the prior year.

I want to personally thank my officers, the board members, the committee chairs, and committee members that worked tirelessly to bring the membership all the education and networking events held during the year. I am overwhelmed by the dedication and commitment to the chapter that these individuals exhibit. I also want to thank all our sponsors of the chapter, their continued support make it possible year after year to provide the education sessions and networking opportunities throughout the entire year.

It has been an honor and a privilege to serve as the HFMA New Jersey Chapter president for the 2015-2016 Chapter year. I wish all the best to Dan as he starts his year as president.

Heather L. Weber



Heather Weber

A handwritten signature in blue ink that reads "Heather L. Weber". The signature is fluid and cursive.

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Healthcare Under Cyber-Attack: The New Normal

by Joe Carr

For healthcare chief information officers (CIO) and chief information security officers (CISO), nothing turns black hair gray more than a security breach. Even if it's not your organization, when you hear about one you stop dead in your tracks and your palms begin to sweat. You immediately think to yourself, How could this have happen?

The largest healthcare breach ever reported occurred in 2015 when Anthem (the second-largest payer in the world) reported that 78.8 million patient records were compromised. In fact, according to Modern Healthcare¹ four of the five largest breaches across all industry segments occurred in healthcare in 2015, and they happened to well-funded healthcare organizations with top-notch security technologists who had ample resources to protect information using "state-of-the-art" tools.

The thought crosses everyone's mind that if this can happen to them, it can happen to anyone. You struggle to find that one fact in all the published reports that makes them look bad and helps you rationalize how this happened and why it won't happen to you, but you can't. As you pour over case after case on all four of the 2015 reported breaches, which exposed a total 104.3 million patient records, you suddenly realize this is not a technology problem - this is a workforce problem.

In almost every incident, an employee fell for a phishing e-mail that enticed them to do something to put their organization at risk. And yes, even high-level information technology executives got hooked and pulled in. Dr. John Halamka, chief information officer of the Beth Deaconess Medical Center said it best, "We are only as secure as our most gullible employee."

Many ask, "Why healthcare and why now?" In the information age, it was just a matter of time before the bad guys figured out how to turn bits and bytes into dollars and bitcoins. Healthcare by far is the most information-rich industry. In one full patient record containing all available HIPAA-defined patient identifiable protected health information (PHI), there are a total of 17 different combinations of personal identifiable information (PII) that each have a black market value based on a specific purpose. It's a hacker's multi-purpose, multi-marketable "dream" data set. As a result, healthcare data is worth 10-20 times more on the black market than standard stolen identity information.

Back in the "good old days", when the typical hacker was a "Script Kiddie" (a very smart high school or college kid with resources, time and nothing better to do), they hacked because

they could. Low on the malice scale, this was an embarrassing disruption.

Script Kiddies continue to be a real threat, but today hackers tend to be much more professional with a well-thought-out approach and objective. They are typically well-educated, extremely clever and are well-funded by state governments, organized crime, political activist groups and terror organizations. They can work from next door or from the other side of the world, far exceeding the long arm reach of the law.

They have done their homework on healthcare and know that a large hospital or health system with many employees in their work force is a ripe target for taking their bait.

They seem to be focusing on provider organizations with ransomware attacks and are not as interested in stealing data. They have apparently realized that a large payer organization has far more patient data than any one provider organization. That's not to say a hacker won't try to steal patient data from a provider, but considering there is a greater opportunity for payoff by simply encrypting patient data and charging a bitcoin ransom to release it, stealing a provider's patient data has apparently become a secondary objective.

As threats continue to evolve, so does our need for situational awareness. Conventional wisdom and even HIPAA security rules recommended "data at rest" encryption as an important breach safeguard. Now we know that a hacker will use ransomware to take control and encrypt even encrypted data, rendering it useless unless the organization pays the bitcoin ransom.

Organizations that catch a ransomware attack early on have an opportunity to thwart the attack, but once your system and back-ups are encrypted, there is really not much an organization can do. Some unofficial reports have cited FBI advice to pay the hacker, which, if true, shows even they understand the dire consequences and know prosecution is not possible. Some argue that the bitcoin currency system is to blame, since this non-traceable monetary system is an enabling tool to collect the ransom. This same argument could be made about the internet in general. The odds of shutting bitcoin down or kicking hackers off the internet is very low, but seeing some legislative activity related to this would not be a surprise as countries all struggle to combat organized crime.



Joe Carr

According to the 2015 Verizon Breach Report², for two years in a row, across all industries, 66 percent of breach incidents were attributed to phishing attacks. Twenty-three percent of people open and read a phishing e-mail, 11 percent click on an attachment and fifty percent click on a phishing link within one hour of receiving the e-mail. The distant second cause for breach incidents was attributed to outdated security updates and patches. The report also points out that as long as an organization updates software within a year of the update becoming available, the cyber-attack threat is reduced to about .1 percent. Most organizations update software routinely and most security updates occur automatically once they become available and are rolled out by the software vendor. This tells us that hacking is essentially not a technical problem. It's a workforce problem.

As a result, many organizations have resorted to orchestrating phishing exercises on their own workforce as a way to raise awareness and gauge where additional workforce training might be required. Tricking your own employees into breaching your security policies needs to be done carefully, since you need employee support to fight phishing attacks and this tactic may risk alienating them. For years now, provider organizations have had to provide annual privacy and security training as required by the HIPAA rules. If done right, phishing exercises included in the annual training will not only help equip employees with knowledge that can help keep the organization safe, but it could also help them and their families to protect their personal computing resources at home as well.

When Dr. Halamka first mentioned during a security webinar that he put security awareness stickers on employee cafeteria salads and sandwiches at Beth Deaconess Medical Center, the idea seemed humorous. Perhaps this might spark an important conversation among employees over lunch. An enlightened employee may one day call the helpdesk to report a suspicious e-mail that contains a lethal ransomware attack that could be stopped before it renders an organization's systems useless. Encouraging and rewarding vigilant employees is as equally important as sanctioning employees for risky behavior.

On May 20, 2015, Governor Chris Christie signed an executive order to create the New Jersey Cybersecurity and Communications Integration Cell (NJCCIC) under the direction of New Jersey Homeland Security. This multi-industry cyber-security agency has a team dedicated solely to protecting the healthcare industry. This past January, David Weinstein, New Jersey's Cybersecurity Director, announced a partnership between NJCCIC and the National Health Information Sharing and Analysis Center to share bi-directional, real-time cyber threat intelligence directly with New Jersey healthcare providers.

Once an attack occurs anywhere in the nation, it's important that all related attack intelligence get disseminated to all trusted healthcare organizations. This situational awareness is an essential way to combat cyber threats as they surface. New Jersey hospitals have already proven the value of sharing real-

time cyber-attack intelligence with the NJCCIC and other New Jersey healthcare organizations. Timely intelligence, complete with specific technical detailed information about a new threat, can be extremely helpful to an organization security posture. There may be that one dangerous e-mail that an employee hadn't open yet that could be identified and deleted.

Additionally, firewall technology has evolved greatly over the last few years. Equipped with timely cyber-attack intelligence, the new firewall technology allows us to detect and discard dangerous e-mails before they ever get into an organization's network or e-mail server. Stopping threats before they get inside an organization eliminates any potential human errors.

Fighting cyber-attacks unfortunately is the new "normal" for healthcare that will require the entire industry's support within and across organizations. There is a great deal of valid concern from trustees, senior leadership and across the entire healthcare workforce. Fighting cyber threats will require a significant ongoing investment in education, tools and personnel. It's also going to require an ongoing, relentless effort that will need to evolve to protect our industry from an enemy that is also motivated to do harm. They too will evolve.

It is encouraging to see the industry stand together sharing ideas, information, best practices and support. Life Lock reports that one in four people have already had their identities stolen, so this isn't just a healthcare problem. These current cyber security threat issues have been a concern for years in CISO circles. Now that those concerns have come to fruition, this problem will need to be addressed not just for healthcare, but for all industries and for our entire new way of life in this information-based internet age.

Footnotes

¹Modern Healthcare Feb 29, 2016

²Report found on njhimss.org under past events.

About the author

Joining the New Jersey Hospital Association (NJHA) in October of 2000 as Chief Information Officer, Mr. Carr has responsibility for all information and communication technologies for the Association and its umbrella of companies. Before joining NJHA, Mr. Carr was the senior vice president of software development at QuadraMed Corporation. While part of the senior leadership team, QuadraMed completed their initial and secondary public NASDAQ offerings.

Mr. Carr is a certified professional in healthcare information and management systems by the Healthcare Information and Management System Society (HIMSS) and currently serves on the NJ HIMSS Board. He also served as chapter president 2013 & 2014. In Nov of 2010 Mr. Carr was appointed by Governor Chris Christie to a two year term on the New Jersey Health Information Technology Commission.

Mr. Carr has a bachelor of sciences degree (Information Sciences) from the Richard Stockton College of New Jersey (1984). He can be reached at jcarr@njha.com.

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Increasing Awareness of the Zika Virus

by Cathleen D. Bennett, Acting Commissioner, New Jersey Department of Health



Cathleen D. Bennett

The Zika virus outbreak is causing international concern with the World Health Organization declaring the outbreak a public health emergency. The severity of this outbreak highlights the importance of a strong public health system to fight emerging diseases. While we don't expect large outbreaks of Zika in the United States, combatting the virus and its related health effects requires close surveillance, preparedness and prevention to protect our residents.

The Department of Health began a public awareness campaign to inform the public—and is asking healthcare providers to partner with us to educate patients about Zika. As part of the #ZapZika campaign, I joined top physicians at the Department to share information with pregnant women in health centers and hospitals, physician groups, college students, professional medical societies and public health officials. The campaign also includes radio and transit advertising encouraging pregnant women to avoid travel to Zika-affected countries and travelers to take steps to prevent mosquito bites.

While it is rare for an individual with Zika to get seriously ill or die, the Centers for Disease Control and Prevention (CDC) has found that the virus can be passed from a pregnant woman to her fetus, and infection during pregnancy can cause a serious birth defect called microcephaly and other severe brain defects. CDC has issued travel advisories for more than 40 countries where virus transmission is ongoing and has recommended that pregnant women postpone travel to these counties.

The Department is asking healthcare providers to counsel women of childbearing age about Zika and encourage them to postpone travel where transmission is ongoing. If a woman must travel, please emphasize protective measures such as using EPA-registered insect repellents, wearing long pants and long sleeves when possible, and removing standing water around areas they are staying. Although uncommon, sexual transmission of Zika has also occurred. Therefore, providers should advise pregnant women and their male partners who have recently traveled to Zika-impacted countries to

consistently and correctly use condoms during sex for the duration of the pregnancy or abstain from sex during the pregnancy.

The Department has conducted conference calls with more than 500 healthcare professionals, maternal and child health providers, and public health officials to share information about Zika. We will continue to share CDC guidance and alerts via our New Jersey Local Information Network and Communication Systems (LINCS) alert system, and we have posted all those materials on our website <http://www.nj.gov/health/cd/zika/index.shtml>. Infographics and videos are also available in Spanish, Portuguese and Creole. Providers can receive alerts by creating an account at <http://njlincs.net/>.

We ask that all providers stay up-to-date on the latest developments, remember key disease prevention protocols, ask about travel history and stay alert for those with symptoms. It is important to regularly check the CDC website, <http://www.cdc.gov/zika/index.html>, as they continue to update guidance and travel advisories. Working together, we can increase our preparedness and protect our residents from the Zika virus and its devastating health consequences for pregnant women and their children.

Follow the New Jersey Department of Health on Twitter at twitter.com/NJDeptofHealth and on Facebook at facebook.com/NJDeptofHealth.

Frequently Asked Questions

What is Zika virus (Zika)?

Zika is a viral infection that is usually spread by the bite of an infected mosquito. It can sometimes be spread by having sex with an infected man. Outbreaks typically occur in tropical Africa and southeast Asia. In May 2015, Brazil reported the first outbreak of Zika in the Americas. Zika is now present in many tropical areas. It has not yet been spread in the continental United States.

Who gets Zika?

Anyone who gets bitten by an infected mosquito, or who has unprotected sex with an infected man can become infected with Zika.

How do people get Zika?

People most often get Zika through the bite of an infected *Aedes* mosquito. This is the same mosquito that spreads dengue and chikungunya. People can also get Zika by having unprotected sex with an infected man.

What are the symptoms of Zika?

About one in five people develop symptoms and infection is usually mild. The most common symptoms are fever, rash, joint pain or red eyes. Other common symptoms include muscle pain and headache. Symptoms usually begin two to seven days after being bitten by an infected mosquito and last several days to a week. Hospitalization and deaths from Zika are unusual, but a nerve disorder, Guillain-Barré Syndrome, can rarely follow an infection. The biggest concern is related to birth defects that have been seen when pregnant women become infected.

How is Zika diagnosed?

The symptoms of Zika are similar to those of dengue and chikungunya, which are diseases caused by other viruses spread by the same type of mosquitoes. See your healthcare provider if you develop the symptoms described above and have visited an area where Zika is present. If you are at risk, your healthcare provider may order blood tests to look for Zika or other similar viruses.

What is the difference between Zika, dengue and chikungunya?

All of these viruses cause similar symptoms, but certain symptoms suggest one disease or another. Most Zika patients have skin rashes; Most dengue patients have a higher fever and more severe muscle pain; Most chikungunya patients have a higher fever and more intense joint pain in the hands, feet, knees, and back.

What is the treatment for Zika?

There is no specific treatment for Zika. Symptoms are treated by getting rest, drinking fluids to prevent dehydration and taking medicines such as acetaminophen or paracetamol to relieve fever and pain. Aspirin and other non-steroidal anti-inflammatory drugs (NSAIDs), like ibuprofen and naproxen, should be avoided until dengue can be ruled out to reduce the risk of increased bleeding.

Can people with Zika pass the illness to others?

Zika needs a vector (a means of transportation) to infect people; generally, that vector is the mosquito. However, Zika virus has been found in semen and person-to-person sexual transmission has been documented. Travelers to an area with Zika should continue to take steps to prevent mosquito bites for three weeks after they leave the Zika-affected area to avoid spreading the virus, even if they do not feel sick. Only one in five infected people develop symptoms. Zika virus can be found in the blood of an infected traveler and passed to another mosquito through mosquito bites. An infected mosquito can then spread the virus to other people.

How can Zika be prevented by avoiding mosquito bites?

No vaccine or preventive drug is available at this time. The best way to prevent Zika is to avoid mosquito bites when traveling to an area where Zika is present.

- Use an EPA-registered insect repellent. Many insect repellents are safe for pregnant women and children to use, but be sure to check the product label for any warnings and follow the instructions closely.
- When indoors, use air conditioning, window screens or insecticide-treated mosquito netting to keep mosquitoes out of the home.
- Reduce the number of mosquitoes outside the home or hotel room by emptying or routinely changing standing water from containers such as flowerpots, pet dishes and bird baths.
- Weather permitting, wear long sleeves and pants when outdoors.

For information on how best to be protected against all diseases related to travel, visiting a clinician with expertise in travel medicine is recommended before a planned trip.

What is the risk of Zika in pregnancy?

Mounting evidence supports a link between Zika and microcephaly, a birth defect that is a sign of incomplete brain development, and possibly other problems such as miscarriage and stillbirth. The rate of these complications is not known but is being studied further. It is unknown how to prevent these possible pregnancy complications, but unintended pregnancies can be prevented.

How can sexual transmission of Zika be prevented?

CDC recommends that men with a pregnant partner should use condoms every time they have sex or not have sex for the duration of the pregnancy. To be effective, condoms must be used correctly from start to finish, every time during sex. This includes vaginal, anal or oral (mouth-to-penis) sex.

- Couples with men who have confirmed Zika or symptoms of Zika should consider using condoms or not having sex for **at least six months** after symptoms begin. This includes men who live in or traveled to areas with Zika.
- Couples with men who traveled to an area with Zika but did not develop symptoms of Zika should consider using condoms or not having sex for **at least eight weeks** after their return in order to minimize risk.

Couples who do not want to get pregnant should use the most effective contraceptive methods that they can use consistently and correctly, and they should also use condoms to prevent the sexual transmission of Zika.

How long should I wait to get pregnant?

For women and men who have been diagnosed with Zika virus or who have symptoms of Zika including fever, rash, joint pain or red eyes after possible exposure to Zika virus, CDC recommends:

- Women wait **at least eight weeks** after their symptoms first appeared before trying to get pregnant.
- Men wait **at least six months** after their symptoms first appeared to have unprotected sex.

For men and women without symptoms of Zika virus but who had possible exposure to Zika from recent travel or sexual contact, CDC recommends healthcare providers advise their patients wait at least eight weeks after their possible exposure before trying to get pregnant in order to minimize risk.

Where can I get more information on Zika?

- Your health care provider
- Your local health department (directory of local health departments in NJ: <http://www.state.nj.us/health/lh/documents/lhdirectory.pdf>)
- NJ Department of Health: <http://www.nj.gov/health>
- Centers for Disease Control and Prevention (CDC): <http://www.cdc.gov/zika/index.html>
- CDC Travel Health Notices: <http://wwwnc.cdc.gov/travel/notices>
- For the most updated information for timing of pregnancy after Zika exposure and prevention of sexual transmission, visit the CDC website: www.cdc.gov/media/releases/2016/s0325-zika-virus-recommendations.html

This information is intended for educational purposes only and is not intended to replace consultation with a health care professional. Adapted from Centers for Disease Control and Prevention and Pan American Health Organization.

Revised 4/18/16

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The Uninsured and The Underinsured – a Possible Solution

by William J. Thomas, C.L.U.



William J. Thomas

According to the Kaiser Family Foundation, there are still more than 900,000 uninsured individuals in New Jersey under the age of 65 who do not qualify for Medicaid. The number one reason why these people don't sign up for Affordable Care Act (ACA) insurance is because they don't know what to do or what's available. Most people don't understand common health insurance terms such as co-insurance and deductible let alone the ACA's tax subsidies. In 2015, only 3 percent of people enrolled in the ACA were able to correctly calculate this subsidy.

Additionally, enrollment in ACA plans is primarily a computer-based process which is not readily available to lower income families. According to the U.S. Census Bureau, for households earning \$35,000 a year or below, the percentage with Internet access in New Jersey is only 55 percent.

New Jersey also has a large Latino population, which, despite outreach, has been largely underserved by the health care law. A 2015 Robert Wood Johnson Foundation survey found that more than 50 percent of Latinos polled had heard or read "nothing at all" or "not that much" about the health care exchanges.

As for the 65-and-older population, there are more than 200,000 seniors who don't have supplemental insurance to accompany their Medicare even though there are many plans that do not require a paid premium. Again, the common thread is the lack of understanding. These seniors are exposed to 20 percent coinsurance for many services, but many do not have the resources to pay.

Face-to-face consulting and education are successful methods for getting people enrolled in health insurance. In New Jersey, there is a robust population of licensed insurance agents who have gone through stringent CMS training and testing to serve both of these segments of citizens in the state. In this group of agents, there are many Latinos and other nationalities with special language skills.

Agents can hold educational events in the hospital and in the community locations the hospital serves. They can also attend health fairs, benefit runs, charitable parties, and other hospital-sponsored events. Once people are educated, they can have appointments with agents, sign up for insurance at events or call a call center manned by New Jersey-licensed and CMS-trained agents.

An enrollment program using your local insurance professionals should cost you nothing but could possibly save you thousands per insured patient. These are the steps to take to have a successful program.

Find a General Agency to work with you to provide you with a group of trained and vetted agents. You will need several agents assigned to your program because the open enrollment periods for the ACA and Medicare are condensed into the final three months of the year. A General Agency, like mine, can organize the agents for you, schedule appointments and events, and provide a call center. The General Agency will also finance the events or co-finance them with you.

The next step is planning, which should happen as early in the year as possible. This planning should include reviewing the hospital's scheduled events and the scheduling for specific education and enrollment meetings. These events could be held in a meeting room at the hospital and hosted by an agent for 10 to 20 people at a time.

Next is communication. This would include everything from the hospital's newsletters, emails, website and a possible mailing to known uninsureds. The General Agent's call center could take reservations for events and their communications department could design and produce all of the necessary communication material. Again, the hospital should have no or little expense since the agents will be earning commissions.

A final key to making this work for the people is to make sure that everyone's health plan will cover their doctors and hospital.

By partnering with a General Agency, you can tap into a pipeline of agents with the skills and knowledge to educate your patient population on how to acquire and better utilize their health insurance coverage.

About the author

Mr. Thomas is the supervisor of the ACA department of Ritter Insurance Marketing. He has been in the New Jersey health insurance business since 1969. In New Jersey, Mr. Thomas pioneered the self-insurance of medical benefits, Managed Medicaid and HMOs. He also reformed the New Jersey prison health care system saving the state tens of millions of dollars. Mr. Thomas can be reached at: bill.thomas@ritterim.com.

Millennials Force Healthcare in Digital Direction

by Bruce Haupt



Bruce Haupt

Millennials raised in the digital age with the convenience of online services are driving healthcare providers to change how they engage with patients and improve the customer service aspect of care. While older generations value in-person communication and cultivating relationships with medical professionals, millennials desire a different approach.

Accustomed to instant gratification, millennials don't want to phone in for an appointment and then wait weeks to see a doctor. Nor do they like to be locked in to health plan network restrictions. They often will search online for healthcare information, even before seeing a doctor.

A key finding in a global survey of over 3,000 people is that millennials tend to select doctors based on referrals from family and friends. But while older patients express dissatisfaction directly to doctors, millennials share unsatisfactory experiences with friends, often on a social network. The survey also revealed that this generation is likely to trust social feedback, handing providers another challenge. Not only do providers need an online presence, they must monitor and manage their social reputation.

Millennials aren't tied to the notion that they must have one specific doctor; they don't develop personal relationships with them. For standard checkups and consultations, some don't feel the need to see a doctor at all, opting instead to see a physician assistant or nurse practitioner.

They don't want to spend hours at a doctor's office for minor medical complaints. Part of this is due to millennials

being generally healthy; pressing health concerns typically are for accidents or injuries rather than chronic illnesses. But it's also reflective of how they consume goods and services. Why shop at the mall when online is more convenient and expedient?

As degreed professionals in executive positions, millennials have good private insurance. However, with rising healthcare costs and patient pay responsibility, they are covering more of the bottom line for medical services, like everyone else. As a result, they are extremely price conscious and demand the best care. According to a report from PwC's Health

Research Institute, millennials age 18 to 34 are most likely to ask for a discount, ask for a cheaper treatment option, request a price check or appeal an insurance decision.

In order to stay competitive, providers need to focus on attracting this population. Their spending power, behaviors and choices have set the stage for digitally oriented generations to come.

Millennials raised in the digital age with the convenience of online services are driving healthcare providers to change how they engage with patients and improve the customer service aspect of care.

About the author

Bruce Haupt is responsible for the business operations of ClearBalance, from sales and marketing through client implementation, program performance, funding, IT and client services. He joined the company in 2013 as senior vice president of sales and marketing, bringing a focus and discipline that has enabled ClearBalance to improve its industry leadership position. Bruce has 25 years' healthcare and IT experience at large corporations including McKesson and IBM.

•Who's Who in NJ Chapter Committees•

2016-2017 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.

COMMITTEE	PHONE	DATES/TIME ACCESS CODE	MEETING LOCATION
CARE (Compliance, Audit, Risk, & Ethics)			
Chairman: Susan Hatch – shatch@virtua.org	(856) 355-0723	First Thursday of the Month	Conference Calls
Co-Chair(s): Lisa Hartman Weinstein – lisahartman@hotmail.com	(609) 718-9982	9:00 AM	
Deborah Carlino – carlindl@ca.rutgers.edu	(973) 972-3260	Access Code: 274-926-602	
Board Liason: Tony Panico – apanico@withum.com	(973) 532-8847		
Communications			
Chairman: Elizabeth Litten – ELitten@foxrothschild.com	(609) 896-3600	First Thursday of each month	Fox Rothschild offices
Co-Chair(s): Al Rottkamp – ajcr123@aol.com	(201) 821-8705	Access Code: 549-853-204	997 Lenox Dr Bldg 3
Board Liason: Brian Herdman – bherdman@cbiz.com	(609) 918-0990 x131	No June or July Meetings	Lawrenceville, NJ
Education			
Chairman: Stacey Bigos – Sbigos@njha.com	(609) 275-4017	First Friday of each month	Conference Calls
Co-Chair(s): Mary Cronin – mmcronin@aol.com	(732) 589-9613	10:00 AM	
Sandra Gubbine – Sandra.Gubbine@atlanticare.org	(609) 484-6407	Access Code: 207-716-687	
Board Liason: Mike McKeever – mmckeever@saintpetersuh.com	(732) 745-8600 x5089		
Certification (Sub-committee of Education)			
Chairman: Rita Romeu – Romeu@comcast.net	(973) 418-6071	First Friday of each month	Conference Calls
Board Liason: Mike McKeever – mmckeever@saintpetersuh.com	(732) 745-8600 x5089	10:00 AM	
FACT (Finance, Accounting, Capital & Taxes)			
Chairman: Tony Palmerio – apalmerio@barnabashealth.org	(732) 923-8638	Second Wednesday of each Month	
Co-Chair(s): Karen Henderson – khenderson@withum.com	(973) 532-8879	8:00 AM	Conference Calls
Board Liason: Scott Mariani – smariani@withum.com	(973) 532-8835	Access Code: 587-991-674	
Institute 2016			
Chairman: Dan Willis – dkwillis6@gmail.com	(201) 803-4067	Third Wednesday of each Month	
Co-Chair(s): Mike McKeever – mmckeever@saintpetersuh.com	(732) 745-8600 x5089	8:00 AM	Conference Calls
Board Liason: Dan Willis – dkwillis6@gmail.com	(201) 803-4067	Access Code: 207-716-687	
Membership Services/Networking			
Chairman: Brittany Pickell – BPickell@ConvergentUSA.com	(732) 221-0785	1st and 3rd Friday of each Month	Conference Calls
Co-Chair(s): Peter Demos – pdemos@meridianhealth.com	(732) 751-3378	9:30 AM	In-person Meetings
Maria Facciponti – mfacciponti@adreima.com	(973) 614-9100	Access Code: 808-053-286	by Notification
Board Liason: Megan Byrne – megan.byrne@ey.com			
Patient Access Services			
Chairman: Maria Lopes-Tyburczy – MLopes-Tyburczy@palisadesmedical.org	(201) 295-4028 / C: (201) 744-8505	6/9/16, 9/8/16, 11/10/16,	RWJBarnabus Corporate
Co-Chair(s): Dara Derrick – dara.derrick@atlantichealth.org	(908) 850-6870	1/12/17, 3/9/17, 5/11/17	379 Campus Drive 2nd Floor Conf Room
Andrew Webber – awebber@medixteam.com	(201) 406-1097	2:30 PM	Somerset, NJ 08873
Board Liason: Belinda Puglisi – BPuglisi@childrens-specialized.org	0: (908) 301-5458 / C: (862) 251-0753	Access code: 542-364-749	
Patient Financial Services			
Chairman: Steven Stadtmuer – sstadtmauer@csandw-llp.com	(973) 778-1771 x146	Second Friday of each Month	Besler Office 3 Independence Way,
Co-Chair(s): Marie Smith – msmith1@rbmc.org	(732) 324-5053	10:00 AM	Suite 201 Princeton – June - Nov. 2016
Board Liason: Josette Portalatin – jportal@valleyhealth.com	(201) 291-6017	Access Code: 714-898-796	CBIZ Office 50 Millstone Road BLDG 200,
			STE 230 – Dec. 2016 - May 2017
			East Windsor, NJ 08520
Payer and Provider Collaboration			
Chairman: Thomas Barnes – barnest@sjhmc.org	(973) 754-2136	Third Wednesday of each Month	alternating locations each month
Co-Chair(s): Ruth Fritsky – Ruth.fritsky@amerihealth.com	(609) 662-2503	2:00 PM	United Healthcare, Iselin, NJ
Board Liason: Jill Squiers – Jill.Squiers@AmeriHealth.com	(609) 662-5347	Access Code: 202-013-321	Horizon BCBS, Wall Township, NJ
Physician Practice Issues Form			
Chairman: Dara Quinn – DaraQ@villagecare.org	(908) 247-9165	7/14/16, 9/8/16, 11/10/16	Conference Calls
Co-Chair(s): Melody Hsiou – mhsiou@kpmg.com	(818) 451-3580	1/12/17, 3/9/17, 5/11/17	
Board Liason: Deborah Carlino – carlindl@ca.rutgers.edu	(973) 972-3260	9:00 AM	
		Access Code: 703-211-177	
Regulatory & Reimbursement			
Chairman: Peter Demos – pdemos@meridianhealth.com	(732) 751-3378	Third Tuesday of each Month	Monmouth Shores Corp. Park
Co-Chair(s): Rachel Simms – rsimms@ubhc.rutgers.edu	(732) 235-3420	9:00 AM	Meridian Conf. Room 1C
Board Liason: Scott Besler – sbesler@besler.com	(732) 598-9608	Access Code: 175-802-794	1350 Campus Pkwy, Neptune
Revenue Integrity			
Chairman: Edlynn Lewis – edlynn.lewis@rwjuh.edu	(732) 418-8077	First Wednesday of each Month	
Co-Chair(s): Pam Hoon – pam.hoon@atlantichealth.org	(973) 451-2089	9:00 AM	Princeton HealthCare System
Jay Mullaney – jmullaney@barnabashealth.org	(732) 923-8435	Access Code: 351-605-588	
Board Liason: Tracy Davison-Dicanto – Tdavison-dicanto@princetonhcs.org	(609) 529-9461		
CPE Designation			
Chairman: Lew Bivona – ldbcpa@verizon.net	(609) 254-8141		

●Focus on Finance●

Cybersecurity Attacks: Prepare or Pay 17,000 in Bitcoin?

By Meghan Watson



Meghan Watson

I am hearing about hospitals taking a hit from ransomware cyber-attacks. Can you share some details about these incidents? And what can my facility do to prevent something similar from happening?

Cybersecurity is a popular topic in the healthcare industry as many healthcare organizations have not appropriately identified the risks and vulnerabilities of their environment. A California hospital was recently reported paying ransom “bitcoin” to unlock critical files. Now another hospital has come forth, declaring an “internal state of emergency” as they comb through their options.

It is not the first time and unfortunately, it will not be the last that a hospital is the focus of a cyber- attack.

The story of a Southern California hospital broke in February after they fell victim to a hacker using malware to infect the institution’s computers, who then demanded 17,000 in bitcoin. If you are not a technology professional, go ahead and Google ‘bitcoin’ – that is complicated in and of itself. However, regardless of the ransom payment method, the attack left the hospital’s system down for more than a week preventing communication amongst employees and restricting access to administrative operations. In order to restore functionality, the hospital had to pay the ransom and obtain a decryption key. While patient records were not compromised according to the news and statements provided by the hospital, there was a significant impact to the hospital on every level related to public trust, operational efficiency and financial metrics. Unfortunately, all too often, organizations react to this type of event rather than proactively protect against it. Although some may argue, it’s hard to ‘get ahead’ of the hackers, there are steps you can take to reduce your vulnerability. Presented below are thoughts around the challenges of cybersecurity and managing your risk.

Cybersecurity Challenges

For an effective cybersecurity program, an organization needs to coordinate its efforts throughout its entire information system. The most difficult challenge in cybersecurity is the ever-evolving nature of security risks themselves. Traditionally, organizations have focused cybersecurity resources on perimeter security to protect only their most crucial system components and

defend against known threats.

Today, this approach is insufficient, as the threats advance and change more quickly than organizations can keep up. As a result, advisory organizations promote more proactive and adaptive approaches to cybersecurity. Similarly, the National Institute of Standards and Technology (“NIST”) issued the Cybersecurity framework in February 2014 that recommend a shift toward detection (continuous monitoring and real-time assessments), response and recovery based on a data-focused approach to security as opposed to the traditional perimeter-based model.

Managing Cyber Risk

The National Cyber Security Alliance (“NCSA”), through SafeOnline.org, recommends a top-down approach to cybersecurity in which corporate management leads the charge in prioritizing cybersecurity management across all business practices. NCSA advises that companies must be prepared to “respond to the inevitable cyber incident, restore normal operations, and ensure that company assets and the company’s reputation are protected.” NCSA’s guidelines for conducting cyber-risk assessments focus on five key areas:

- Identifying your organization’s “crown jewels” or your most valuable information requiring protection;
- Identifying the threats and risks facing that information and their likelihood of occurrence;
- Assessing the impact of the damage your organization would incur should that data be lost or wrongfully exposed;
- Assessing the organization’s ability to recover from such an event and planning for timely and appropriate response; and
- Detecting any nefarious activities (i.e. breach) on your network.

Specific to healthcare, organizations should evaluate the risk to electronic PHI (“e-PHI”) when at rest on removable media, mobile devices and hard drives. We would suggest deploying appropriate measures to safeguard all data stored on

portable devices. The media should be encrypted and portable devices should employ a remote device wipe technology to remove data if lost or stolen.

Cyber risk assessments should also consider operations and any regulations that impact the manner in which your organization collects, stores and secures data. Assessing processes and technologies will help to establish the requirements of a mature cybersecurity program, but an organization must also focus on the people who touch those processes and technologies. The most robust cybersecurity program involving technology solutions will be limited without a high level of ‘user adoption’ emdash; your employees understand the risks, embrace their responsibilities and act accordingly. Proper change management can aim to improve or create a governance framework, communication plans, job impact analysis and appropriate training/education to help ensure the success of the cybersecurity efforts.

In conclusion, many healthcare organizations have not appropriately identified the risks and vulnerabilities of their environment, and therefore are failing to adequately safeguard protected health information (“PHI”) and other sensitive data. It is critically important in today’s world to assess your organization’s current state of readiness regarding its ability to Identify, Protect, Detect, Respond, and Recover from a security incident and to take action to achieve your targeted level of readiness going forward.

Similar Threats Across the Ocean

The United States is not the only country vulnerable. The core healthcare services and internal systems at two German hospitals have now also been disrupted by ransomware attacks.

One of the hospitals, Lukas, has reportedly reverted to phone calls, faxing and physical record-keeping for the past few weeks, while the IT systems have been offline. The hospital has also postponed high-risk surgeries until systems are up and running. Fortunately, the IT team at Lukas performs regular backups, but there is a possibility that some data and patient records have been lost.

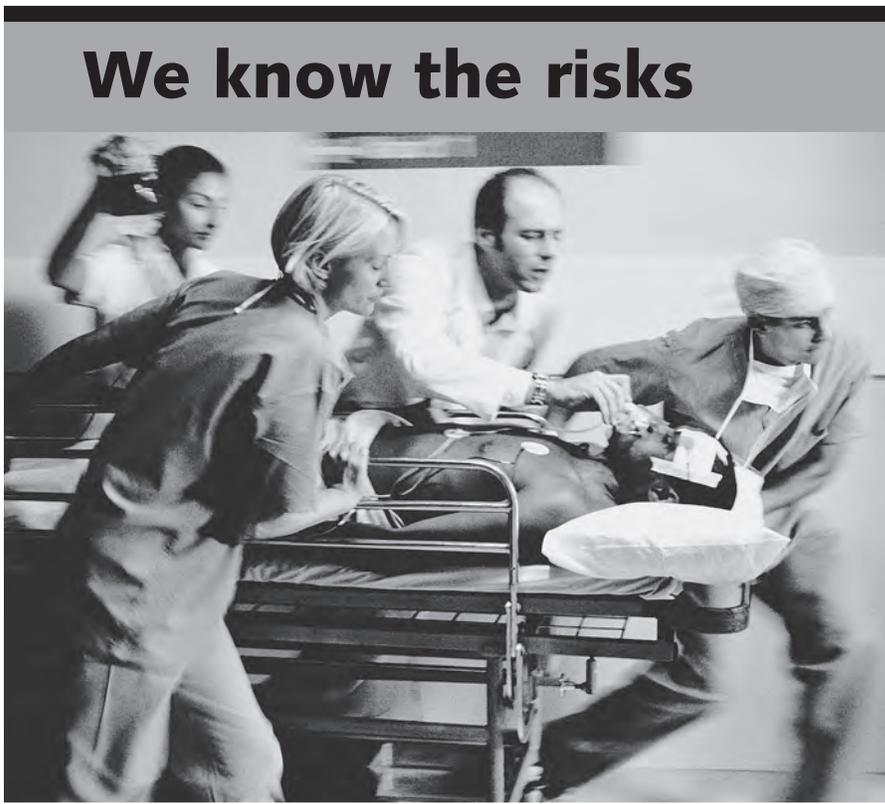
Another hospital, Klinikum Arnsberg, confirmed that it was targeted in a ransomware attack via an email containing malware. Instant action taken by their cybersecurity teams resulted in the hospital containing the damage: the virus was detected in one server and the other 199 servers were immediately switched

off to prevent any further contamination by the malware.

So far, both these hospitals are refusing to pay the ransom. Deutsche Welle, a German publication, reports that it will “take weeks” for the hospitals’ systems to be back to normal.

About the author

Meghan Watson is Team Leader of Management Consulting Services with WithumSmith+Brown, Certified Public Accountants and Consultants. She can be reached at mwatson@withum.com.



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HIPAA Audits

by Jessica Forbes Olson and TJ Lang

On March 21, 2016, the Office of Civil Rights (“OCR”) announced it will launch a second round of HIPAA audits during 2016. As with the first round of audits, in round two OCR will be reviewing compliance with HIPAA Privacy, Security and Breach Notification rules. New for this round, the 2016 audits will focus on covered entities, including health care providers and health insurers, and their business associates.

The round two audits will occur in three phases: desk audits of covered entities, desk audits of business associates, and finally, onsite reviews. It is reported OCR will conduct about 200 total audits; the majority of which will be desk audits.

OCR has already begun the process of identifying the audit pool by contacting covered entities and business associates via email. Health care providers, insurers and their business associates should be on the lookout for automated emails from OCR which are being sent to confirm contact information. A response to the OCR email is required within 14 days. OCR instructed covered entities and business associates to check their spam or junk email folders to verify that emails from OCR are not erroneously identified as spam.

After the initial email, OCR will send a pre-audit questionnaire to entities it may choose to audit. Receiving a pre-audit questionnaire does not guarantee your entity will be audited. The purpose of the questionnaire is to gather information about entities and their operations, e.g., number of employees, level of revenue, etc. The questionnaire will also require covered entities to identify all of their business associates. Health care providers and insurers who have not inventoried business associates should do so now.

Entities who fail to respond to the initial OCR email or questionnaire will still be eligible for audit. OCR will use publicly available information for unresponsive entities to create its audit pool.

Health care providers, health insurers and business associates should check their HIPAA compliance status before they are contacted by OCR. Once selected for an audit, entities will only have 10 business days to provide the requested information to OCR.

OCR will then, in the “coming months,” randomly select entities to audit and notify them via email that they have been selected for audit.

Health care providers, health insurers and business associates should check their HIPAA compliance status before they are contacted by OCR. Once selected for an audit, entities will only have 10 business days to provide the requested information to OCR.

Recent OCR enforcement activity has shown that non-compliance with HIPAA can be costly:

- A Minnesota-based hospital entered into a \$1.55 million settlement for failure to implement one business associate agreement and failure to conduct a HIPAA security risk analysis;
- A teaching hospital of a university in Washington entered into a \$750,000 settlement for failure to conduct an enterprise-wide HIPAA security risk analysis;
- An insurance holding company based in Puerto Rico entered into a \$3.5 million settlement for failure to implement a business associate agreement, conduct a HIPAA security risk analysis, implement security safeguards and for an improper disclosure of protected health information (“PHI”);
- A radiation oncology physician practice in Indiana entered into a \$750,000 settlement for failure to conduct a HIPAA security risk analysis and implement security policies and procedures.

If you receive any communications from OCR please contact a member of the Fox Rothschild Health Law practice group immediately. A proactive review of your HIPAA compliance status can identify potential gaps and minimize the risk of potential penalties.

A HIPAA compliance checklist for health care providers and insurers follows:



Jessica Forbes Olson



TJ Lang

- ❑ Determine whether for HIPAA purposes you are a hybrid entity, an affiliated covered entity or part of an organized health care arrangement. Document that status.
- ❑ Appoint a HIPAA privacy official.
- ❑ Appoint a HIPAA security official.
- ❑ Appoint a HIPAA privacy contact person who will handle complaints and respond to the exercise of patient or participant rights.
- ❑ Determine where PHI is located, whether hard copy, electronic, or spoken.
- ❑ Determine the reasons why PHI is used or disclosed (e.g., treatment, payment, health care operations, public health reasons, public policy reasons, to government agencies or officials).
- ❑ Determine which departments and workforce members have access to PHI, why they have such access and the level of access needed.
- ❑ Identify and document the routine requests, uses and disclosures of PHI and the minimum necessary for those requests, uses and disclosures.
- ❑ Identify all business associates: vendors that create, maintain, use or disclose PHI when performing services for your entity.
- ❑ Have executed business associate agreements with all business associates.
- ❑ Have and follow written HIPAA privacy, security and breach notification policies and procedures.
- ❑ Train all workforce members who have access to PHI on the policies and procedures and document the training.
- ❑ Have and use a HIPAA-compliant authorization form.
- ❑ Have and follow process for verifying the status of personal representatives.
- ❑ Distribute a notice of privacy practices and providers must attempt to obtain acknowledgment of receipt of notice from patients and post one in each facility where patients can view it.
- ❑ Establish and document reasonable administrative, technical and physical safeguards for all PHI, including hard copy and spoken PHI.
- ❑ Conduct and document a HIPAA security risk analysis for all electronic PHI (e.g., PHI on desktops, laptops, mobile phones, iPads and other electronic notebooks, copy machines, printers, discs and thumb drives).
- ❑ Address risks to ePHI that are identified in the HIPAA security risk analysis.

***A proactive review of your
HIPAA compliance
status can identify
potential gaps and
minimize the risk
of potential penalties.***

- ❑ Update your HIPAA security risk analysis periodically or when there is a material change in your environment that does or could impact PHI or if there are changes in the law impacting PHI.
- ❑ Encrypt PHI to fall within the breach safe harbor.
- ❑ Have written disaster recovery and contingency plans.
- ❑ Prepare for and respond to security incidents and breaches.
- ❑ Comply with HIPAA standard transactions and code set rules related to electronic billing and payment.
- ❑ Although it will not be covered by the audits, comply with more stringent state privacy and security laws (e.g., document retention; patient consent; breach reporting).
- ❑ Maintain HIPAA compliance documentation in written or electronic form for at least 6 years from the date the document was created or last in effect.

For more information about OCR audits or assistance in conducting a HIPAA compliance review, please contact any member of the Fox Rothschild Health Law practice group.

About the authors

Jessica Forbes Olson is partner of Fox Rothschild LLP and a member of its Employee Benefits & Compensation Department and its Health Law practice group. She assists group health plans, health insurers, health care providers and their business associates comply with HIPAA. Jessica likes to say that she has grown up with HIPAA since she started practicing law, with an emphasis on HIPAA, the year before the HIPAA privacy regulations became effective in 2003. Jessica can be reached at jforbesolson@foxrothschild.com.

TJ Lang is an associate with Fox Rothschild LLP and is a member of its Employee Benefits & Compensation Department and its Health Law practice group. TJ assists employers and group health plans to maintain compliance with ERISA and HIPAA in the operation and administration of their employee benefit plans. Prior to practicing law, TJ was a project manager with Epic Systems and credits his interest in HIPAA and health law to his time working with health organizations. TJ can be reached at tlang@foxrothschild.com.

Education Update: Chapter Updates Evaluation Process



Michael McKeever

by Michael P. McKeever, CPA, FHFMA, Chair – NJ HFMA Education Committee

If you have attended a recent Chapter educational event you've probably noticed that there's been something missing. As the NJ Chapter has continued to go green, we've eliminated the hard copy evaluation forms and have begun to poll the attendees using Survey Monkey, an online tool that allows us to more easily compile the feedback provided. As anyone who has volunteered at a Chapter event knows, at the end of the day while everyone else is heading for the door to enjoy the networking session or rushing back to the office someone needs to go through the room and pick up all of the hard copy evaluations that are usually left on the tables, along with copies of the agenda, various marketing materials and whatever else the attendees decide they don't want to cart back to the office. And of course once the forms are collected the information still needs to be manually input to a spreadsheet to calculate and quantify the results.

These tasks have been eliminated and replaced by an email containing the link to the evaluation specific to that day's session. The initial message is sent out the afternoon of the session, with a follow up a few days later to remind those who may

have forgotten to "turn in their assignment!" The information obtained through Survey Monkey is easily downloaded to a spreadsheet, which allows for quick dissemination of the results. The new process was previewed at the March 4 Medicare Cost Report Session, and used again for the March 8 CARE/Physician Practice Issues Forums sessions. It was also used for the North/South Free Education sessions and the recent Women's Leadership and Development Session. The Chapter plans to continue to use this tool to obtain feedback on our educational offerings, but will gain the greatest savings in cost and time at the 40th Anniversary Annual Institute that will be held on October 5 – 7 at the Borgata in Atlantic City. In prior years an inordinate amount of paper was needed to obtain feedback on the many sessions presented at the Institute, and a great deal of time was needed to input the data and compile the results. But this year we anticipate a much more efficient process for tabulating and reporting attendee feedback from the 40th Anniversary Annual Institute, as well as the Chapter's many other educational offerings.

Progress. You just can't stop it!

mark your calendar . . .



September 13, 2016

APA Hotel
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**Bi-monthly Educational Meeting
Regulatory & Reimbursement
Committee**

November 8, 2016

APA Hotel
Woodbridge*

All day

**Bi-monthly Educational Meeting
FACT Committee**

October 5-7, 2016

The Borgata,
Atlantic City

Annual Institute

January 10, 2017

APA Hotel
Woodbridge*

All day

**Bi-monthly Educational Meeting
Patient Financial
Services Committee**

*Formerly Hotel Woodbridge

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Director of Patient Financial Services
Bancroft

The Unknown Disability Income Risks Physicians Face in the New World of Healthcare



Robert F. Ehinger

What doctors, healthcare systems, and their advisers need to know, right now

by Robert F. Ehinger

Just as the Hippocratic Oath has changed over the years, the changing face of healthcare underscores the need for physicians today, more than ever, to reexamine their disability income (DI) insurance coverage.

How Changes In Healthcare Have Impacted Physicians' Need For Disability Income Coverage

Numerous changes in the healthcare world have resulted in challenges to the security of their future income that physicians can no longer ignore:

1. **A changing employment landscape.** With consolidations, acquisitions and mergers, as well as changes in employment status from self-employed to employed or to contracted employee, many physicians find that receiving their income protection solely from employer-sponsored plans creates more risk and limits options when that employment ends.

For physicians, control of their income protection with personally owned and portable coverage is important, because the certainty of obtaining benefits through work no longer exists. Physicians and managers

may wish to seek to own and control the products that protect them and their families—so that if relocation is desired or if job loss occurs, they have coverage that continues to protect them, up to and throughout their next engagement.

2. **Being part of a healthcare system.** When hired by a healthcare system, physicians are generally included in the benefit plans, *just like any other employee*. Often, no allowance is made to cover specialized skills and years of learning. Healthcare systems are under great cost pressure and thus maintain restrictive contract definitions that help control the benefits expenditure for the rank-and-file employees. The perhaps unintended consequence of that approach is to put physicians at significantly more personal financial risk.

In most group LTD plans, physicians' unique capabilities are not fully protected after the first two years of a disability. That's because most policies offer "own-occupation" protection (coverage that provides a benefit if a physician is disabled and cannot perform the duties of his or her usual occupation—even if he or she could perform the duties of another occupation) for only two years.

For physicians, control of their income protection with personally owned and portable coverage is important, because the certainty of obtaining benefits through work no longer exists. Physicians and managers may wish to seek to own and control the products that protect them and their families—so that if relocation is desired or if job loss occurs, they have coverage that continues to protect them, up to and throughout their next engagement.

- 3. **Reduced Medicare-related income.** Continued cost containment pressure from CMS can lead to reduced physician income. Group benefit plans that tie coverage to a percentage of W-2 earnings will provide lower benefits as physician incomes fall.
- 4. **Revenue stream changes, partnership income, and incentive compensation can create DI shortfalls.** Today, physicians can receive both base salary and RVU-based income. (Soon, that will include value-based payments.) But because it isn't guaranteed, variable income often isn't benefit eligible, meaning it's not insured under most disability income programs. Neither is any income physicians may receive from partnership interests (e.g., surgical centers)—or other incentive compensation.

Changes in reimbursement regulations and movement to a performance-based culture have generally eroded income protection for physicians. For example, measurement protocols utilizing RVU models ordinarily set up a compensation plan of base salary that is supplemented by incentive compensation derived from work units—which often comprises 50 percent or more of the physician's income. Because this income isn't guaranteed and is considered a "bonus," it is frequently not benefit eligible and excluded from DI coverage. In other cases, many physicians receive substantial compensation—often \$100,000-\$250,000 and more—as partners in surgical and other medical service centers. That income, often shown as K-1 partnership income, is generally excluded from coverage. Similarly, management teams in hospitals or large medical systems often receive incentive compensation, but frequently have no—or limited—coverage for that. In these instances, DI programs need to adapt to cover these types of supplemental income, as the benefit design should correspond to the strategic intent of the compensation plan.

- 5. **Loss of goodwill.** Physician practices no longer have goodwill that is paid upon the sale of the business. The practices themselves have very little capital and equipment and what is negotiated upon the sale of a practice is a higher reimbursement rate for services performed after the buyout, with no cash changing hands. Unlike a normal business that can expect a payment of a multiple-of earnings or revenue, the physician must continue to work within the new financial framework. This makes protection of current and future earnings even *more* critical.

The risk? The physician must acquire new coverage—a difficult task for those who have any significant health issues. Because limited attention is paid to DI coverage, the shortcomings of the initial plan design are often not discovered until it's too late.

- 6. **Loss of infrastructure/little focus on DI benefits.** Because of the change in CMS reimbursements that reduce payments to physicians who work offsite, many practices that were acquired by healthcare systems and hospitals may no longer be profitable, a fact that can result in their spinoff. However, for those physicians who gave up all infrastructure and business processes to become employees, they will find that group benefits are not portable to any significant extent and offer limited protection.

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- 7. **Delayed impact of loss.** Because of the extended revenue cycles in healthcare reimbursements, a physician can suffer a disability or physical limitation and not have a *financial* loss for 90 days or more. Most disability income insurance con-

tracts require a minimum loss of 20 percent of earnings in order to pay a benefit. But the physician could be recovered by the time they are eligible to collect a benefit. Fortunately, state-of-the art contract design can now provide for the payment of benefits for a loss of duties or a loss of time, not simply a loss of income.

- 8. **Over-reliance on group benefits.** Group long-term disability (LTD) coverage is commonly sold by benefit brokers as a standard approach to income protection. Unfortunately, these broad-based plans rarely meet the needs of the physician workforce. Unfortunately, rich group LTD benefits that *appear* to be attractive are actually a double-edged sword, since they limit the ability of the doctor to obtain the higher-quality individual contracts due to the limit on the amount of coverage that the physician can purchase on his or her own.

The insurance industry limits how much disability coverage it will issue, typically providing benefits up to no more than \$25,000 per month for physicians. In a busy metropolitan practice, that is often inadequate coverage. To the extent that the maximum capacity has been taken up by a group contract, physicians cannot obtain the high-quality protection they want. *One solution?* Reduce the group benefit and introduce a supplement-

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tal plan of individual disability insurance that has the portability and key contract provisions that physicians desire. *The win/win?* If the physician-employee pays for the new coverage, the healthcare system lowers its premium expense, yet the physician obtains better coverage.

The Importance Of Working With A Specialist Broker

The importance of disability income coverage is often overlooked, perhaps because disability plan premiums typically comprise no more than 1 percent of an organization's benefits budget. Additionally, because medical personnel usually make up 5 percent to 10 percent of a healthcare system's total employee population, the emphasis is on the 90 or 95 percent—meaning the physicians' critical need for DI coverage can go unrecognized. Similarly, the emphasis on overall benefit costs means that busy HR teams and benefits managers, along with their insurance brokers, usually focus primarily on health insurance and retirement plan costs because they comprise 90 percent or more of their annual benefit expenditures. Consequently, the DI benefit plan for physicians is often neglected.

But disability income insurance is not your average benefit plan. Because DI contracts are technical and income structures in the healthcare arena are complex, clients who seek to optimize their DI insurance programs often ask specialist brokers who work with healthcare companies to orchestrate their customized program.

Why a specialist broker can add so much value

Because physicians frequently have existing DI coverage, an analysis of the existing and proposed coverage to determine which coverage options are in the physician's best interests must often be conducted. The program enrollment teams need to have the time and the interpersonal skills to engage one on one with the physicians as well as the expertise with individual and group contracts. These are capabilities more commonly offered by specialist brokers rather than group brokers.

The end result? Working with a specialist broker can maximize the program value for the sponsoring employer and the physician—and it can create much better overall physician understanding and acceptance.

Both physicians and healthcare systems seeking coverage should look for brokers with strong communication skills, along with a comprehensive command of disability contracts. The ideal broker will also be one who understands the unique needs of the healthcare systems and the physicians to be insured—and is capable of designing a program that's especially suited to meet those needs.

Win-Win Solutions

Despite these challenges, there *are* solutions for today's physicians—through both individual and employer-sponsored insurance.

The Individual Disability Income Insurance Solution

Individual disability income contracts have the unique feature that the benefits are guaranteed never to change, even if income varies. So coverage that fully protected an income of \$400,000 still provides that level of coverage, even if that income eventually falls. Of course, expenses typically don't fall as quickly as income does, so a guaranteed level of protection is important.

With an individual disability income policy, even a change of occupation from a highly compensated situation to a lower-income position can be protected with locking, level benefits. In recent years, too, policy provisions have been enhanced to offer physicians partial benefits, recovery benefits, and payments based on loss of duties versus loss of income.

The Employer-sponsored Disability Income Insurance Solution

Disability insurance is one of the most difficult products to obtain. That's because the insured doesn't need to die in order to collect the benefits. As a result, normal underwriting of individual policies involves proving good health and earnings history. Frequently, neither of those are present, particularly as physicians, like anyone else, can suffer health issues as time goes on. Their income can also vary, or if they are new to the medical profession, they may not have the earnings history that is required for an individually underwritten DI policy.

Recent Developments Benefit Healthcare Systems & Physicians

Fortunately, the consolidation of healthcare systems has added buying leverage. This is due to the fact that large healthcare systems and physician practices can now use their size to obtain comprehensive coverage at discounted prices, often on very favorable terms.

Other developments have also come into play. For example, today, insurers are more willing to issue Guaranteed Standard Issue (GSI) policies to groups of five or more. GSI policies are an outstanding way to provide valuable DI coverage to employees with pre-existing conditions, since there is virtually no underwriting; often, there is no income verification or blood/urine requirements. And substantial group discounts may also be available.

With a GSI policy, applicants obtain guaranteed coverage with no need to show evidence of insurability or provide tax returns. The earnings data is conveniently supplied in aggregate from employer records so that coverage amounts are

pre-approved in a company offer. The convenience of payroll deduction or group remittance in employer-paid plans increases the coverage available.

These are low-cost benefits with high value-added perception and impact. A typical disability insurance program will

Disability Income Plan Design Checklist

1. Is the disability income program specifically designed with the physician-employees in mind?
2. Adequacy of the benefit: Is there enough coverage? Typically, an after-tax benefit that is as close as possible to the physician's actual take-home earnings is ideal.
3. Is all of the income covered, or does the plan cover the physician's base salary *only*?
4. Is variable compensation, such as income from a partnership, covered?
5. How does the contract define "disability?" Does that definition change at any point? Is there protection of specialty skills?
6. Is the coverage portable and non-variable? If a physician leaves his employer, the physician take the coverage with him- or herself, with the same terms remaining in effect? Does the physician own the contract and have the ability to control its benefits?
7. Do the benefits change as earnings vary?
8. Are the coverage and the premium both guaranteed to remain level for the life of the policy, typically to age 65?
9. Is there a cost-of-living adjustment feature?
10. How does the contract cover partial disabilities? Many group LTD contracts have restrictive definitions that can limit or fully offset benefits when a physician continues to work despite an impairment. For example, if a physician works 60 hours a week and due to an impairment can only work 40 hours a week, that still may be considered full-time employment and not generate the payment of benefits, despite a 33 percent loss of income. A physician may lose the ability to perform material job duties, but because of the long delays in the revenue cycle, may not suffer an income loss for 90 days or more. Will the contract pay a benefit at all? No one wants an operation performed by a partially disabled surgeon, so an income loss is inevitable, but the contract won't pay benefits before an extended waiting period.

cost about 1 percent or less of income. By contrast, a 403(b) retirement plan with a 4 percent contribution rate is just that, four times the cost and still not enough to fully fund a physician's retirement. And since defined benefit plans are going the way of the dinosaur, protection of earned income throughout the medical professional's working lifetime is a critical component of financial security.

Of course, hospitals and ACOs are under tremendous cost pressure. But even those organizations that are unwilling or unable to extend broad coverage to their highly compensated professionals can add value by *sponsoring* programs that offer deep price discounts—and access to the very best products on favorable terms that physicians cannot secure on their own.

Often, the Optimal Plan Design Uses a Customized Approach

With respect to either an individual or employer-sponsored policy, the best approach is often one that includes different products, with contract terms that are uniquely structured to the specific needs of the medical professional(s).

For example, a physician may wish to include an own-occupation feature in the policy, which provides benefits if the covered disability precludes him or her from performing the duties of his or her occupation. So for instance, a surgeon who suffers a disability that prevents him from performing surgery could collect benefits, even if his disability is such that he can still function as an internist.

In another example, coverage can be designed to insure income paid through surgical center work, separate and distinct from other income a physician may have. Therefore, unaffiliated physicians can take advantage of the commonality of their locus of operation, the surgical center, so that the center can extend an offer to obtain coverage to its physician partners.

What Advisers To Physician Practices Involved In Mergers & Acquisitions Need To Know

Advisers to physician practices, particularly those involved with mergers and acquisitions, would be wise not to overlook the importance of disability income.

In addition, because of the physicians' demonstrated reliance on future income following an acquisition or merger, attorneys and other business advisors who counsel physicians should be aware of the potential risk that the new entities may present to their clients. Consequently, the adequacy of future benefit program should be an important area of focus—one that is addressed as part of the merger negotiation. Options that could be considered include:

- Negotiating for the physicians' right to contract for disability income insurance benefits separately for the practice, rather than relying entirely on the system's benefit plan, either before or after the merger.

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Important Considerations For Healthcare Systems

Acquisitions: Hospitals involved in acquisitions of physician practices can use the flexibility of a supplemental DI plan to normalize benefit arrangements among entities. That enables them to retain existing structures, if desired, and allow their key people to select the coverage they need, up to an overall shared maximum benefit.

Physician engagement initiatives: Organizations often seek to engage their physicians as partners. Reaching out to physicians with an enhanced disability income program that is well designed and carefully crafted underscores the entity-physician partnership that is essential to their mutual economic success.

Offering physicians valuable ongoing protection: Historically, physicians have protected themselves from disability by initially purchasing programs while in residency. Often, however, because they fail to keep these amounts current, as incomes rise, protection hasn't followed suit. Part of the benefit of the process of enrollment is to engage with physicians professionally and have an informed discussion with them. That can help to create a greater connection between the physician and the sponsoring institution.

- Reviewing the proposed benefit plan and negotiating benefit improvement exceptions prior to any commitment.

Attorneys who represent the parties should address this significant risk. If, after a transaction, a physician receives no or minimal goodwill payments and continues to be 100 percent dependent upon his or her ability to earn an income, isn't the protection of all of that income a critical issue concerning their future financial security?

The healthcare system's legal, financial and business advisors—as well as the management team at the healthcare system itself—would be well advised to consider both the value and the importance of disability income. The Plan Design Checklist shown here gives important considerations when designing a disability income benefit program that will meet the needs of the physicians in the post-merger environment.

Disability Income: The Low-Cost, High-Value Benefit

For at least as long as doctors have been reciting the Hippocratic Oath, they have needed to protect their income against the dangers of disability. It's critical for these highly educated and trained individuals who have expended considerable time and money—and endured extreme personal sacrifice—to achieve the

ability to practice medicine. Disability income insurance can help these medical professionals protect the income and lifestyle that they've become accustomed to.

Fortunately, healthcare systems and their advisers can turn to specialist brokers for assistance in crafting disability income benefits that can help to protect the physicians that are so key to their financial success. It's a low-cost benefit for the employer (or even the physician if the employer doesn't fund the coverage), but it's one that's of vital importance to the long-term financial security of the physician.

About the author

Bob Ehinger has extensive health care practice expertise, and a long history in the financial services industry as an associate of Lee, Nolan & Koroghlian, LLC, one of the largest and most advanced insurance and investment firms serving thousands of corporate and individual clients in the tri-state area. Bob can be reached at rfehinger@financialguide.com.

The need for Disability Income Insurance is real

It's a harsh reality. A disability can strike anyone, at any time.

The Social Security Administration estimates that one out of three Americans entering the workforce today will suffer a disability before they reach retirement age. And most—nearly 90 percent—of disabilities are not job related, which means they are not covered by workers' compensation.*

Despite the many ways an individual can become disabled, it's often impossible to anticipate a disability. Take Dr. Tim C., a Massachusetts physician who is 37 years old**, with a successful medical practice, plus a wife and two young children. Dr. Tim was healthy. He watched his diet carefully, exercised religiously, and made every effort to get the rest he needed, despite the demands on his personal and professional time.

Nevertheless, after receiving an ordinary flu shot three years ago, Dr. Tim developed a severe case of Guillain-Barre that put his life at risk, landing him both in the ICU and, for a time, a wheelchair. Although he did recover after a few years, it was not a full recovery: Dr. Tim only has 80 percent capacity to perform his job as he previously did. Unfortunately, Dr. Tim did not have DI insurance. If Dr. Tim had been insured, he might have been covered for the loss of income his practice sustained due to his partial disability.

* Source: *Facts from LIMRA: 2013 Disability Insurance Awareness Month*

** This is a true case in which the facts and circumstances have been altered to protect the individual's privacy.

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Industry Leaders Share Smart Tips for Compliance Success at Spring NJ HFMA Conference



Melody Hsiou

by Melody Hsiou

On March 8, 2016, compliance professionals from a variety of healthcare backgrounds gathered to attend the annual conference hosted by the Compliance, Audit, Risk & Ethics (CARE) and Physician Practice Issues Forums of NJ HFMA. The conference, titled “Health Care is ‘Risky’ Business! Smart Tips for Compliance Success!” was held at the Renaissance Woodbridge Hotel and was co-chaired by Sue Hatch, Deborah Carlino, Lisa Weinstein, Jennifer Shimek, and Dara Quinn.

This is the second year that the conference has been co-hosted by the CARE and Physician Practice Forums, after the first event in 2015 confirmed that there was significant content overlap between the two forums and participant interest in hearing from both groups. This year’s conference also proved to be a great networking and educational experience and further encouraged the two forums to continue collaborative efforts. In addition to an update from the New Jersey Hospital Association, conference attendees heard from speakers representing a diverse range of the healthcare industry, including hospitals, research centers, health systems, law practices, and consulting firms. The program was designed to address some of the most complex challenges facing healthcare professionals today and included the following sessions:

- **Bret Bissey**, Senior Vice President at MediTract & **Kelly Sauders**, Partner at Deloitte, kicked the day off with a presentation on hot topics in compliance and physician issues, which offered an overview of recent criminal and civil enforcement activities and areas of ongoing OIG audit and investigative focus in the past year. Mr. Bissey and Ms. Sauders noted that criminal enforcement was declining while civil cases were on the rise, with an increased focus on matters related to the 60 day rule, specialty pharmacies, alternative payment models, false claims and kickbacks, conflict of interest disclosures, and cybersecurity. Mr. Bissey emphasized that there could be increased enforcement against corporate executives with the Yates memo,

and observed that several recent whistleblower cases originated from high level management, including from within compliance departments themselves. The session also highlighted the latest risks to consider in hospital-physician arrangements and notable recent settlements and cases.

- **John Coleman** from the Prescription Drug Research Center spoke about the pressing new issues surrounding medicinal drugs and potential drug diversion. Dr. Coleman, who served 32 years as a Special Agent of the US Drug Enforcement Administration (DEA), aimed to bridge the information and understanding gap between the medical and regulatory communities on complex drug diversion issues. Dr. Coleman spoke about the rising epidemic of prescription drug use and the correlation to number of drugs diverted, as well as the economics supporting the drug diversion market. He noted that hospital and clinic thefts were a serious and growing problem with potential harmful implications to patients. In a sobering recent statistic, more than 100,000 medical personnel were found to have been abusing drugs. As possible solutions to this problem, Dr. Coleman proposed increasing education and monitoring, proper storage and disposal, cooperation between the medical and pharmaceutical industries, and stringent auditing and enforcement.
- **David Sokolow**, Partner at Fox Rothschild, gave attendees an overview on the current state of hospital and physician contracting. Mr. Sokolow spoke about contracting in the context of continued consolidation in the health care industry, movement toward narrow networks, value-based care and pay-for-performance arrangements, and increased focus on hospital-physician affiliations and collaborations. Concurrently, physician/hospital contracts must take into account fraud and abuse trends, court cases and regulatory developments, chart-topping False Claims Act settlements, and ever-changing revisions to leading

fraud and abuse authorities such as the latest round of Stark Law revisions under the 2016 Medicare Physician Fee Schedule Final Rule. Mr. Sokolow explored these recent developments, their impact on hospital/physician contracting, and the proactive steps that could be taken to reduce the potential of fraud and abuse.

- **Robert Hussar**, Healthcare Counsel at Manatt, **Richard Kileen**, Director of Purchasing at Hackensack UMC & **Jennifer Shimek**, Principal at KPMG, presented a panel on third party vendor risk. With deep experience on managing third party risk, the panel identified common issues facing healthcare organizations and shared best practices. The panelists discussed how third parties can present risks to supply chain, contracting, conflicts of interest, training and education, sanction screening, regulatory accreditation standards, and HIPAA breaches. Attendees were particularly interested in the challenge of oversight in large organizations and how to utilize time to monitor controls and processes. A best practice shared by all three experts was the need to extract and document a list of true vendors in order to identify risk and centralize vendor management. Dara Quinn, Chief Compliance Officer at VillageCare and Co-Chair of the NJ HFMA Physician Practice Issues Forum, moderated the panel.
- **Mark Johnson**, Managing Director at KPMG, gave attendees an eye-opening primer on the state of Information Security in Healthcare, discussing issues arising from HIPAA, OCR, cybersecurity, social media, phishing, and hacking. Speaking about the “New Normal,” Mr. Johnson introduced healthcare’s new cyber threat profile, the top causes of information security breaches, and the exponentially growing market for patient/member health information. In 2015 alone, there were over 100 million health records stolen by outside hackers and the number is only expected to increase with the transition from paper to electronic health records. Mr. Johnson stated that although cybersecurity has been identified as a top threat by many healthcare organizations, many organizations do not educate their staff on the consequences of a security breach or on how to make the right security decisions. While Mr. Johnson stated that it would be impossible to foresee and prevent all potential security risks, a strong security program could act as a metaphorical seatbelt to lessen the damage. Mr. Johnson concluded with a call to action, asking attendees to align their security and privacy programs to the new threat model.
- **Jim Robertson & John Kaveney**, attorneys at McElroy, Deutsch, Mulvaney & Carpenter, shared guidance on how to handle overpayments. While awaiting final regulatory guidance on the 60-day repayment requirement that was included in the Affordable Care Act, the court in *Kane v.*

Healthfirst, Inc. stepped in to interpret the language, specifically as it relates to when the overpayment is “identified” and, thus, the clock on the repayment obligation begins to tick. Mr. Robertson and Mr. Kaveney spoke about the implications of Kane and the effect it may have on future governmental enforcement. Prior to Kane, most providers interpreted the term “identified” to mean that the overpayment has been identified and quantified, hence “classified with certainty,” however, the decision suggests that identification occurs when a person is put on notice of possible overpayment. Thus, providers should be more proactive in their overpayment detection efforts. The speakers stressed that while each case would likely undergo unique analysis, providers must work to create robust compliance programs with timely auditing in order to avoid the appearance of knowing retaining or recklessly disregarding a claim overpayment in violation of the False Claims Act. In February 2016, CMS guidance clarified that an overpayment has not been “identified” under the 60-day rule until a provider has or should have, through “reasonable diligence,” quantified the overpayment.

- **Tom Flynn**, Vice President & Chief Compliance Officer at Hackensack University Health Network & **BJ Welsh**, Chief Compliance Officer at Saint Peter’s Healthcare System, provided an assessment of the Office of Inspector General’s 2015 Governing Board Guidance on Compliance Oversight. As compliance professionals at two major regional health systems, Mr. Flynn and Ms. Welsh shared their tips on how to evaluate compliance program structure beyond the seven traditional elements. The speakers addressed evolving areas of risk and how to validate that the scope and adequacy of compliance programs in the context of organization complexity. Also discussed was the important relationships that are now essential to the effectiveness of the compliance function, such as interdependence with the General Counsel, Internal Audit, Human Resources and Quality Improvement. Attendees gained a better understanding of the expectations for board reporting including objective scorecards, the use of internal and external benchmarks, mechanisms for accountability, and monitoring of corrective actions.

About the author

Melody Hsiou, JD, MPH, CHC, is Co-Chair of the Physician Practice Issues Forum, NJ Chapter HFMA and a consultant in KPMG’s Forensic and Regulatory Compliance Practice. Melody conducts compliance and HIPAA risk assessments and provides recommendations to assist a diverse range of healthcare clients in becoming compliant with federal and state regulations. Melody is a licensed attorney in New York and New Jersey. She can be reached at mhsiou@kpmg.com

Integration of Behavioral and Physical Health Care: Licensing and Reimbursement Issues¹

by John V. Jacobi and Tara Adams Ragone²



John V. Jacobi

People with behavioral health conditions suffer from missed health care opportunities. Research has shown that people with serious mental illness suffer from increased burdens of sickness and early death as a result of poorly managed physical illness. People with less significant behavioral conditions too often remain unconnected to mental health or substance use disorder care because such services are unavailable in primary care settings. Clinicians responding to these system deficits advocate care integration that brings primary care and behavioral health under one roof.

Innovative New Jersey clinicians are working toward behavioral health integration. The clinical difficulties such integration entails can be daunting, but models from around the country, as well as home-grown efforts, point the way toward success. Clinicians have reported, however, that their efforts are impeded by legal barriers in New Jersey's licensure and reimbursement systems. The Nicholson Foundation asked Seton Hall Law School's Center for Health & Pharmaceutical Law & Policy to examine those legal barriers, and to propose solutions that would facilitate appropriate behavioral health integration.

The full report on which this Article is based reviews the clinical behavioral health literature and describes the statutory and regulatory law on licensure and reimbursement. It reflects extensive conversations with many primary care and behavioral health providers, academics, advocates, and government representatives. The generosity of these interlocutors greatly aided in translating the general and formal to the specific and contextual, allowing the authors to understand the law *as applied* to behavioral health integration efforts. The openness and candor of government representatives at all levels were particularly helpful.

The Report had several goals. First, the statutory and regulatory framework is complex, and the regulated community experiences confusion that impedes efforts to extend care. One goal, therefore, is to describe in clear terms both the "black letter" law and, equally as important, authoritative interpretations of that law as applied to behavioral health integration.

Second, the Report describes those instances in which current law impedes the development of integrated care. In some instances New Jersey law appears to lag the clinical developments in this area, suggesting that modifications in the law could benefit all. The Report details such areas in the licensure and reimbursement areas.

Finally, the Report offers recommendations for adjustments to the regulatory framework governing reimbursement and licensure. The recommendations are intended to provide a balance between the consumer protection missions of the Departments of Human Services and Health on the one hand, and the imperative to facilitate the move to clinically integrated behavioral health and primary care services on the other. One extremely positive development is that, during the course of the Report's development, the New Jersey Departments of Human Services and Health announced a forward-looking policy innovation allowing the sharing of clinical space for behavioral and primary care in licensed facilities. The Departments' movement is consistent in many regards with recommendations in the Report, and suggests continuing regulatory advances to accommodate integrated care.

The Report summarizes the literature on clinical advances to behavioral health integration. It details important areas of clinical consensus, as well as areas that continue to develop.

- The drive to integrate primary and behavioral health care responds to the evidence that people with serious behavioral health conditions suffer for lack of access to primary care, while people with mild to moderate behavioral health conditions, too often unconnected to



Tara Adams Ragone

behavioral health care, could benefit from access to care in primary care settings.

- The drive to integrate care goes beyond merely increasing access; rather, studies demonstrate that behavioral health integration can improve patient outcomes.
- Integrating care appears to be cost-neutral or cost-saving. Many high-utilizers of hospital emergency department services have behavioral health conditions, and appropriate community care of both their behavioral health and physical health needs could reduce the need for expensive hospital-based care.
- Development of behavioral integration faces several environmental barriers, including gaps in reimbursement, low Medicaid reimbursement rates, and onerous licensure standards.

Many New Jersey behavioral health and primary care providers regard licensure rules to be a principal barrier to integrated care. Discussions with these providers revealed that there is a great deal of confusion among the regulated community as to New Jersey's licensure rules.

- Federally Qualified Health Centers (FQHCs) and other outpatient clinics are an important source of primary care for New Jerseyans with low or moderate incomes. FQHCs are licensed by the Department of Health (DOH) as Ambulatory Care Facilities (ACFs).
- The ACF regulations list permissible services, which include some limited outpatient substance use disorder treatment but not mental health services.
- Mental health programs (MHPs) and outpatient substance abuse treatment facilities (SAs) are licensed by the Department of Human Services (DHS). This structure often requires that integrating facilities are required to obtain two or three separate licenses, an onerous task.
- In practice, however, both DOH and DHS permit DOH-licensed FQHCs to provide limited mental health services, such as screening, brief intervention, and limited counseling and medication management, without being licensed by DHS.
- The extent to which DOH and DHS permit ACFs to provide behavioral care is quite ambiguous in New Jersey's laws and regulations.
- Mental health programs and outpatient substance use disorder treatment programs licensed by DHS are not permitted to provide most primary care services without obtaining a separate ACF license from DOH; however, DHS-licensed mental health programs are often permitted, by informal arrangement, to provide up to eight hours of primary care per week without a DOH license.
- Hospital-based outpatient facilities located away from the hospital campus must be separately licensed as ACFs

by DOH. In addition, if a hospital licensed for mental health care does not offer outpatient behavioral health services on its hospital campus and operates more than one off-campus outpatient behavioral health facility, DOH will only consider one of these programs as being under the hospital's license; additional such facilities must be licensed by DHS as a MHP.

- It is unclear whether hospital-based outpatient clinics are permitted to provide integrated behavioral health and primary care services without obtaining a license from DHS, although DOH acknowledged that integration may be appropriate in certain circumstances.

A major sticking point with many facilities striving to provide integrated care has been the State's position that behavioral and primary care may not be provided in the same clinical space. A memorandum released by the DOH on October 19, 2015, referred to here as the Shared Space Waiver, provided a means for relaxation of those requirements for integrating ACFs.

- Prior to the publication of the Shared Space Waiver, providers reported being told that they must maintain separate entrances, stairways, restrooms, waiting rooms, examination rooms, staff break rooms, and other duplicative facilities, most but not all of which requirements were confirmed in interviews with DOH. DOH did report that waivers from some of these requirements were commonly permitted.
- Many of these "keep separate" requirements appear to run contrary to nondiscrimination requirements, including those of the Americans with Disabilities Act.
- The Shared Space Waiver, issued by DOH pursuant to the Commissioner's waiver authority, relieves many facilities of most of those "keep separate" requirements for facilities seeking licensure from both DOH and DHS.

In addition to licensure barriers, payment issues inhibit behavioral health integration in many circumstances.

- The system by which FQHCs and other ACFs may be paid by Medicaid for behavioral health services is complex and often misunderstood by providers. The agency instructions for and implementation of Medicaid billing is located in several uncodified locations, subject to interpretation by several sources, and has been reported to be inconsistently administered.
- Although DHS has taken the position that DOH-licensed ACFs must also be licensed as mental health programs by DHS in order to bill Medicaid for mental health services, DHS has approved, through the distribution of informal guidance, certain limited reimbursement codes to be activated for FQHCs to provide some limited behavioral health services.

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- Almost all Medicaid recipients in New Jersey are now covered by Medicaid Managed Care Organizations (MCOs). Because New Jersey Medicaid operates with a behavioral health carve-out, however, some but not all behavioral health services are not reimbursed by MCOs, but by an independent contractor on a fee-for-service basis. This system has created some confusion, and DHS has shifted management of Medicaid payment for substance use disorder treatment to Rutgers University Behavioral Health Care, and is in the process of reexamining the system by which mental health care is reimbursed.
- FQHCs receive Medicaid payment through a unique prospective payment system, intended to compensate them for providing a broad range of comprehensive clinical and other health-related services.
- The FQHCs' prospective payment rate is adjusted to account for medical inflation. In addition, the amount of payment is required to be adjusted when an FQHC experiences a "change in scope of services."
- The precise definition of what constitutes a change in scope, triggering an adjustment to the FQHCs' payment rate, is not defined in federal or state statute, but the law allows states some discretion in such matters.
- There is a long-standing disagreement between many FQHCs and DHS over precisely what modification of services triggers an obligation to file an application for a change in scope. This dispute appears to be a factor in some FQHCs' decision to add behavioral health services sufficient to permit the integration of primary and behavioral care.
- Some states administer FQHC reimbursement in a manner that allows FQHCs some leeway in adjusting their services without the need to file a change of scope application.

The Report provided recommendations for adjustments to the licensure and reimbursement rules in New Jersey in order to facilitate the adoption of behavioral health integration. The recommendations are summarized below:

- DHS and DOH should collaborate to simplify the regulatory requirements for integrated care, as the agencies did in publishing a Waiver to Permit the Sharing of Clinical Space on October 19, 2015 (the Shared Space Waiver).
- The Departments should collaborate to facilitate the dual licensure of providers to operate integrated care facilities, and over time should move to a single license for the operation of an integrated facility, with collaborative sharing of expertise between the agencies.
- Regulatory requirements for separation of behavioral and primary care services should be eliminated, a goal significantly advanced by the Shared Space Waiver;

building on that step, the agencies should eliminate all requirements for separation except for those, such as records maintenance, required by law. Facilities regulations should be functional, encouraging shared space and services where not inconsistent with patient needs.

- Medicaid payment rates for primary care and behavioral health services, including those paid through Medicaid managed care organizations, should be reviewed in order to assure sufficient financing to sustain integrated care.
- DHS should continue to pursue initiatives such as Behavioral Health Homes and the Certified Community Behavioral Health Clinics project to ensure that people with serious and persistent behavioral health needs have access to necessary physical health services in an integrated setting.
- The Change of Scope process for FQHC reimbursement should not be allowed to serve as a barrier to FQHCs' ability to maintain or add behavioral health services for mild to moderate behavioral health conditions.
 - DHS should clarify the extent to which FQHCs can provide care for mild or moderate conditions without requiring a change of scope filing; and
 - If such a filing is required, DHS and regulated entities should engage in a collaborative process to ensure that regulatory requirements do not impede efforts to serve the needs of patients.
- Health care providers in New Jersey attempting to provide integrated physical and behavioral health services appear to receive inconsistent guidance on licensure and reimbursement. DHS and DOH should provide more user-friendly tools to combat confusion in the regulated community. Such steps might include:
 - FAQs and more complete descriptions of regulatory policy on integration on agency web sites.
 - Public outreach to mental health programs, FQHCs and other primary care providers, hospitals, and their trade organizations with full descriptions of agency policy.

Footnotes

¹This article is drawn from a longer Report, John V. Jacobi, Tara Adams Ragone, and Kate Greenwood, *Integration Of Behavioral And Physical Health Care: Licensing And Reimbursement Barriers And Opportunities In New Jersey* (Seton Hall Law School Center for Health & Pharmaceutical Law & Policy, March 11, 2016) available at <https://issuu.com/seton-hall-law-school/docs/integration-of-behavioral-and-physi?e=19054437/34560793>. Corresponding author, John V. Jacobi, john.jacobi@shu.edu. The Report was produced with the support of The Nicholson Foundation.

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Tiered Benefit Plans: in the Crosshairs

by Neil M. Sullivan, Esq.

Tiered health benefits plans are plans that have more than one level of in-network benefit. Insureds have a financial incentive to use service providers in the first tier – usually through one or more of lower deductible, coinsurance or co-payment. They can get covered services from providers in the second tier, but at a higher out-of-pocket cost.

To some, tiered benefit plans are the future of health benefits – focusing services efficiently through a core team of service providers working together to increase quality while holding down costs. To others, they represent a triumph of backroom deals over best-practices medicine, with insurance bureaucrats wresting healthcare delivery decisions from doctors and their patients, and usurping the State's rightful oversight of the delivery system as those relegated to the second tier fight for survival.

As care becomes more directed, two issues become paramount – is the capacity in that first tier sufficient to provide the access advertised, and how were those providers selected?

The network adequacy dialogue that is now taking place in New Jersey was in some ways made inevitable by the Affordable Care Act. Traditionally, the levers to control prices of health insurance plans included plan design (what is and is not covered), cost-sharing (deductibles, copays and coinsurance), and reimbursement (how much is paid by the plan considering both price and volume). For individuals and small groups the ACA largely fixed the plan designs by defining essential health benefits and requirements for Qualified Health Plans, and the cost-sharing, by defining bronze, silver, gold and platinum plans primarily through application of varying cost-sharing. For insurers to differentiate their pricing in the marketplace this led to increased pressure on the third lever, and ratcheting down price and volume frequently meant deeper discounts and more tightly coordinating care through a winnowing of the networks.

Tiered networks have been around in New Jersey for the past few years, but the issue was pushed into overdrive when New Jersey's largest insurer made a major push in this direction with the introduction of Horizon's Omnia plan at the end of last year. Driving great volume to the first tier inevitably affects both the services received by a larger portion of the population and financial viability of those providers not in the

first tier. How was this hierarchy determined? Horizon has generally responded that its process is proprietary.



Neil M. Sullivan

State Network Adequacy Requirements

New Jersey saw its first tiered benefit filings while I oversaw the Office of Life and Health at the New Jersey Department of Banking and Insurance. Existing network adequacy requirements were the only regulatory tools available by which to approve or disapprove these plans. We held to the position that the first tier of the network had to meet the existing adequacy requirements. It would be misleading, it seemed to us, to market a plan as having an inexpensive first tier in an area where the first tier providers were geographically out of reach. It was not a popular position with the carriers filing the products, but the industry seems to have embraced it since. While I was at the Department I had occasion to discuss network adequacy issues with my peers in other states. I was struck by the number of states that did not have any network adequacy requirements set out in regulation, particularly for managed care plans of insurance companies.

For Health Maintenance Organizations, New Jersey's network adequacy standards are codified at *N.J.A.C. 11:24-6.1 et seq.* In summary they call for:

- a sufficient number of primary care providers,
- adequate numbers of specialists by type, each of which must be sufficient to ensure access within 45 miles or one hour driving time, whichever is less, of 90 percent of members within each county or smaller service area; and
- an array of institutional providers meeting time and distance criteria.

For insurance companies other than HMOs, analogous requirements are found at *N.J.A.C. 11:24A-4.10.*

A small but very professional and diligent staff at the Department is dedicated to reviewing the submissions, and they are very thorough and very experienced.

However, historic network adequacy measures - including New Jersey's - are necessarily rough. They tend to count heads

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by practice type, bricks and mortar buildings by accreditation type, and where those heads and buildings are geographically in relation to membership. This puts a premium on volume and proximity over quality, and doesn't factor in the reality that some practices are more limited than their specialty alone suggests. In the past, networks tended to be more inclusive than exclusive, and when nets are cast widely there is little risk that quality will be excluded or necessary subspecialties unavailable. As networks or tiers are established more narrowly, these issues loom larger. It is also true that changes in delivery model increasingly make time and distance standards less relevant. We saw this in New Jersey with the 2009 autism insurance reform. When individuals certified in behavior analysis are performing their activities in the patient's environment, how relevant is the mileage to their office? Similarly, when Medicare and other payers are supporting electronic means of communication between patients and providers, how important is geography for those services?

At the end of the day, health insurance purchasers are interested in whether they will be able to get quality services they need, when and where they need them. While historic measures may have served us well in the past, it is understandable we find ourselves in the middle of new policy discussions at the State and Federal levels concerning appropriate guardrails in this new emerging landscape. And it is appropriate that conversation expands from time and distance to encompass criteria for selection. Advocates on both sides have debated whether the designation 'Tier 1' in and of itself denotes higher quality, but there is no denying that when families are financially incented to receive their care within a narrow circle, there is a societal interest in how that circle was constituted.

It is also an economic reality that many providers rely on commercial insurance reimbursement levels to compensate for shortfalls in reimbursement for charity care and under-paying government programs. Tiering structures that could avoid providing that cross-subsidy by steering commercial patients to providers with more affluent patient bases could threaten the viability of safety-net providers. Even without reliance on the cross-subsidy, many care providers contracting with carriers agreed to price concessions in the expectations that patients would be steered toward them. Relegated to second-tier status, they now find those tiered plans steering patients to their competition.

NAIC Model

The National Association of Insurance Commissioners took up the issue on a national level and adopted a new "Health Benefit Plan Network Access and Adequacy Model Act" in 2015, to take on many of these concerns.

NAIC Models are instructive in that they generally represent the consensus thinking of the nation's insurance commissioners on the issue at hand, and therefore carry weight with many leg-

islators and Insurance Departments. Of course any national network adequacy model must necessarily leave many of the specifics to local authorities – requirements that may work in populous New Jersey will surely be an impossible standard in states like Montana. Putting aside local issues, however, the 2015 Network Adequacy Model Act incorporates the following design elements:

- The definition of network adequacy affirmatively incorporates the obligation to include those providers who serve predominantly low-income, medically underserved individuals to meet adequacy standards;
- The Model places greater emphasis on the ability to get authorization for out-of-network providers at in-network cost-sharing, if the specific sub-specialty is either absent from the network or otherwise not sufficiently available to a patient. This includes reporting requests for out-of-network access and carrier responses to the Insurance Commissioner, who can then better monitor network adequacy;
- Requiring carriers to file an adequacy plan with the Insurance Department, which would include use of telemedicine, out-of-network authorization processes, and the criteria for network selection;
- Transparency requirements, including participation status of hospital-based physicians, and cost ranges for those out-of-network; and
- A mediation process for disputed out-of-network bills for providers not selected by the patient.

CMS on Network Adequacy and Tiered Networks

The Centers for Medicare and Medicaid Services (CMS) has established network adequacy requirements that apply to Qualified Health Plans, which are generally plans that have been qualified to sell on the Federal Marketplace. These are codified at 45 CFR § 156.230. Under these rules, carriers are generally required to maintain adequate networks, which may be defined by state regulations. Carriers are more specifically also required to include a sufficient number of providers that serve predominantly low-income, medically underserved individuals (Essential Community Providers), maintain provider directories that are accurate and up-to-date, and provide continuity of care when providers leave the network. As in New Jersey, the current rules make no reference to tiering.

Interestingly, CMS sought input on possible additional standards when it proposed its "Notice of Benefit and Payment Parameters for 2017":

"In the proposed rule, we solicited comments on a number of other network adequacy standards, including standards included in the work being done by the NAIC's Network Adequacy Model Review Subgroup. Our solicitation of comment included...

Whether issuers should be required to make available their selection and tiering criteria for review and approval by HHS and the State upon request.”

CMS did not act on the comments in finalizing the rule, but had this to say in the preamble on those two issues:

- “We encourage issuers to be more transparent about selecting and tiering criteria. We believe that transparency of selecting and tiering criteria would help enrollees and providers better understand how the issuer designed its network, which could help enrollees use the network more effectively and efficiently.
- “We are not implementing additional network adequacy related provisions at this time. Our intention is to give States time to adopt the NAIC Network Adequacy Model Act provisions and potentially reconsider this area in the future.”

This suggests we may yet hear more from the Federal government on this issue.

The ACA’s Prohibition on Non-discrimination

An intriguing unknown in all of this is the new and largely untested prohibition in the ACA on health plans’ discriminating against licensed health care providers.

PHSA section 2706(a), as added by the ACA, says that a “group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider’s license or certification under applicable State law.” However, the section “shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer.” It further provides that nothing in the section prevents “a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures.” Similar language is included in section 1852(b)(2) of the Social Security Act and HHS implementing regulations.

So the ACA prohibits discrimination in plan participation against any licensed practitioner, stops short of adopting an “any willing provider” standard in health plans, and permits varying reimbursement by quality or performance measures. The NAIC and CMS actions described above, both of which acknowledge the advent of tiered benefit plans, post-date this statutory requirement. It would therefore appear those bodies do not consider relegating some duly licensed providers to a separate tier with lower reimbursement as per se discriminatory under Section 2706(a). But an about-face on what the section does mean by the Departments responsible for implementation may be illuminating:

“Provider Non-Discrimination FAQs about the Affordable Care Act Implementation Part XV” published jointly by HHS, DOL, and the Department of Treasury on April 29, 2013, included the following in response to question 2 regarding this section of the law:

“This provision does not require plans or issuers to accept all types of providers into a network. This provision also does not govern provider reimbursement rates, which may be subject to quality, performance, or market standards and considerations.”

Subsequently, the Senate Committee on Appropriations issued a report dated July 11, 2013 which criticized this section of the Departments’ FAQs:

“The goal of this provision is to ensure that patients have the right to access covered health services from the full range of providers licensed and certified in their State. The Committee is therefore concerned that the FAQ document issued by HHS, DOL, and the Department of Treasury on April 29, 2013, advises insurers that this nondiscrimination provision allows them to exclude from participation whole categories of providers operating under a State license or certification. In addition, the FAQ advises insurers that section 2706 allows discrimination in reimbursement rates based on broad “market considerations” rather than the more limited exception cited in the law for performance and quality measures. Section 2706 was intended to prohibit exactly these types of discrimination.”

The Departments accordingly pulled back in “FAQs about Affordable Care Act Implementation (Part XXVII)”. It more directly quoted the section of the ACA, and provided the following Q&A:

“Q5. Does Q2 in FAQs about Affordable Care Act Implementation Part XV continue to apply?

No. Q2 in FAQs about Affordable Care Act Implementation Part XV, which previously provided guidance from the Departments on PHS Act section 2706(a), is superseded by this FAQ and notation will be made on the Departments’ websites to reflect this modification.”

While it remains to be seen how far this provision may be employed in challenging carrier network participation and tiering decisions, using criteria that go beyond performance and quality measures are clearly at greater risk of challenge.

Recent New Jersey Legislative Activity

Multiple bills have been introduced in the legislature in the wake of the launch of Horizon’s Omnia plan, attempting to wrestle with this issue from different angles. These include re-

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quiring inclusion of state hospitals in the highest tier, requiring actuarial value disclosure, and establishing a minimum actuarial value for the lowest tier (S296/A2329); freezing enrollment in current tiered plans until legislation and regulations are in place (S1934/A3558); requiring tiering placement based on cost and efficiencies, disclosing tiering criteria, and establishing an oversight monitor (S634/A887); requiring network adequacy to apply to the first tier and prohibiting conditional approvals (S635/A2328); and establishing a Task Force on Tiered Health Insurance Networks (S1512/A888).

Wherever these bills go, they have fostered a much-needed public dialogue on issues of network access and criteria for inclusion in a changing healthcare delivery environment.

About the author

Neil M. Sullivan is a Partner in the Health Care Practice Group at McElroy, Deutsch, Mulvaney & Carpenter, LLP. Mr. Sullivan served as the Assistant Commissioner for Life and Health at the New Jersey Department of Banking and Insurance from March 2010 to March 2014. McElroy, Deutsch Mulvaney & Carpenter has twelve offices in New Jersey, New York, Connecticut, Massachusetts, Pennsylvania, Delaware and Colorado. Neal can be reached at NSullivan@mdmc-law.com.



What's In Your Beach Bag?

NJ HFMA Members share their personal and professional reading picks

The Boys in the Boat - Daniel James Brown
Recommended by Lindsey Colombo

The Nightingale by Kristin Hannah. It is a phenomenal book about the reality of war in France during WWII.
Recommended by Lindsey Colombo

Zapp! The Lightning of Empowerment: How to Improve Quality, Productivity, and Employee Satisfaction, by William Byham and Jeff Cox. It is a great, easy read and applicable to any industry/role in business.
Recommended by Brittany Pickell.

Man's Search for Meaning by Viktor Frankl. It is an autobiography chronicling his experiences as an Auschwitz concentration camp inmate during World War II, and describing his psychotherapeutic method, which involved identifying a purpose in life. Something we all could use as we transcend the changing environment in our industry. It is one of the best books I've ever read!
Recommended by Dave Alexander

In my beach bag – in between the jugs of sunscreen and big hat is a fascinating book *READY PLAYER ONE* by Ernest Cline. This book was a gift to me from Anthony Chiafullo which I just finished two weeks ago. It really brought back a lot of memories for me growing up in the video game culture – there are a lot of inside jokes as well as some references that will bring a smile to the reader. I would say it is along the lines of a funny, science fiction thriller set in a futuristic (and depressed) United States. Also I have heard that Steven Spielberg is making it into a movie for 2017. I have been reading more fiction as they are somewhat more enjoyable but for those that prefer non-fiction I would also recommend *Killing Patton* by Bill O'Reilly – I know it has been out for a while but well worth the read. And for readers that may have read *Blackwater* by Jeremy Scahill – I recommend *Civilian Warriors* by Erik Prince as a rebuttal to *Blackwater*. I would also like to thank Brian Herdman for his review of *The Martian* – still have not seen the movie because I do not believe it can live up to the book.
Recommended by Scott Besler

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Steve Aduato, Connie Merritt and Emily Friedman



Steve Aduato, Ph.D., enjoys a distinguished career as a broadcaster, author, syndicated columnist, university professor and motivational speaker. A trainer and coach in the areas of leadership and communication skills, Steve also served in the mid 1980's as New Jersey's youngest state legislator at the age of 26.

Steve currently anchors three public television broadcasts produced by the Caucus Educational Corporation (CEC) — *Caucus: New Jersey*, an Emmy Award-winning public affairs television series; *New Jersey Capitol Report*, a weekly program covering New Jersey's most pressing policy issues; and *One-on-One with Steve Aduato*, CEC's nightly public television series that brings viewers in-depth interviews with some of the region's most compelling personalities, including artists, authors, health experts, politicians, and sports icons, as well as "ordinary" people who accomplish extraordinary things. Steve has also anchored many high-profile television specials including an exclusive, live primetime interview with Governor Chris Christie and a primetime special with US Senators, Bob Menendez and Cory Booker.



Connie Merritt, RN, BSN, PHN, is an established information agent to leaders – and their teams – since she understands what they are facing as they press forward in this diverse, multi-generational, mobile, high-tech world...on deadline, at every turn.

A seasoned professional with more than 20 years experience of speaking nationally with leading companies, organizations and associations, Connie understands people, the processes and dynamic influences at our door-step today. She has an established reputation of connecting with audiences and providing essential content with step-by-step tactical teachings and motivation to learn the best practice skills and strategies to thrive now and continue to excel in managing tasks and relationships.

In her book, *Too Busy For Your Own Good* (McGraw-Hill), Connie has helped millions of people and organizations make vital adjustments to manage change and maintain focus in a world demanding multiple decisions and responses to lists of requests – an urgent prescription for an over busy, stressed-out nation with

a surefire action plan to help "busyness" casualties heal the habit once and for all.



Emily Friedman is an independent writer, lecturer, researcher, photographer, and health policy and ethics analyst based in Chicago. Among her areas of interest are international health care trends; population health improvement; protection of hospitals in time of civil unrest; future trends in health care; health care reform initiatives; "comparative effectiveness" and other quality improvement efforts; the social ethics of health care; the future of health care leadership; the ethics of health care leadership; health policy and how it works (or doesn't); the impact of demographic change on health care; insurance and coverage issues; and the relationship of the public and society with the health care system. She is an Adjunct Assistant Professor at the Boston University School of Public Health, where she has repeatedly been named one of the School's best teachers; an honorary life member of both the American Hospital Association and the American Medical Association; and a prolific lecturer and writer. She writes a regular column for *Hospitals and Health Networks Daily*, contributes to many other publications, and is the author or editor of several books on ethics, health care history, and other topics. Her recent publications include an examination of minority participation in clinical trials and

an analysis of the impact of population change on all aspects of health care. She recently completed a project focusing on violent attacks on hospitals around the world and how they might be prevented. Since 2007, she has also been writing and speaking about the rebuilding of the Cambodian health care system, which was almost totally destroyed between 1969 and 1979.

Ms. Friedman has been named one of the "100 Most Powerful People in Health Care" and one of the "Top 25 Women in Health Care" by *Modern Healthcare* magazine, and has won many other awards and honors. In 2011, 2012, and 2014, she was named one of the "top five" health care speakers in the United States by *Speaking.com*.

She has also made many appearances on radio and television, including ABC News and National Public Radio.

NJ HFMA Volunteers!

On Saturday June 4th, some of our most generous members dedicated their time to help out at The Community FoodBank of New Jersey in Hillside. From 9am to 11am we worked as a team to unpack, sort and organize hundreds of items – including bottled water, canned goods, boxed food, baby supplies, cosmetic and beauty supplies and cleaning supplies. All of these items are distributed throughout 18 counties in New Jersey to support families in need. Not only was the activity

for a good cause, but we had a blast working as a team and getting to know each other better. As a result of the positive feedback, the Membership & Networking Services Committee plans to offer this opportunity to our members at least twice a year. If you are interested in joining us, contact the committee chair/co-chairs or follow us on LinkedIn and Facebook for more updates. It costs nothing to make a lasting impact in our community!



American Healthcare – Worst Value in the Developed World?

by John J. Dalton, FHFMA

This article is part one of a series that documents American healthcare as the worst value in the developed world, identifies the best performing countries, explores some of the underlying reasons for the disparity between America and its Organization for Economic Cooperation and Development (OECD) counterparts, compares the different approaches taken by France, Germany and the United Kingdom (UK), and concludes with some recommendations for closing the gap.

In its February 8, 2016 issue, *Modern Healthcare's* (MH's) "By the Numbers" (p. 34) tabulated healthcare's share of Gross Domestic Product (GDP) in 2000 and 2013 for the United States and 21 other developed countries that are members of the OECD, and classified those countries by type of universal healthcare system as follows:

- **Insurance Mandate:** Government mandates that all citizens purchase insurance, whether from private, public or not-for-profit insurers (five countries including Austria, Germany and Switzerland).
- **Single Payer:** Government provides insurance for all. Pays all expenses except for copays/coinsurance. (Eleven countries including Canada, Italy, Japan, and the United Kingdom).
- **Two-Tier:** Government provides or mandates catastrophic or minimum coverage for all, while allowing supplemental voluntary insurance or fee-for-service care when desired (five countries, including France, Israel and the Netherlands).

According to the World Health Organization (WHO), universal health care generally refers to a healthcare system that provides health care and financial protection to all citizens of a particular country. It is organized around providing a specified package of benefits to all members of a society with the end goal of providing financial risk protection, improved access to health services, and improved health outcomes. Universal health care is not a one-size-fits-all concept and does not imply coverage for all people for everything. Universal health care can be determined by three critical dimensions:

1. who is covered,
2. what services are covered, and
3. how much of the cost is covered.

The common denominator for all such programs is some form of government action aimed at extending access to health care as widely as possible and setting minimum standards. Most countries implement universal health care through legislation, regulation and taxation. Legislation and regulation direct what care must be provided, to whom, and on what basis. Usually some costs are borne by the patient at the time of consumption but the bulk of costs come from a combination of compulsory insurance and tax revenues.

MH correctly listed the United States as not having universal health care. Its spending as a share of GDP exceeded that of the other 21 developed countries by a wide margin (12.5% vs. 8.1% in 2000; 16.4% vs. 10.0% in 2013). That being the case, I decided to explore whether America's higher level of spending was producing better results for our citizens, and turned to the WHO's 2014 Global Health Indicators. Data were available for 1990 and 2012, so I began with life expectancy at birth, both sexes, and incorporated that data (see Table 1, Changes in Healthcare Share of GDP 2000-2013 and Life Expectancy 1990-2012, 22 OECD Nations). To my disappointment, American healthcare lagged the other 21 developed countries with an average life expectancy at birth of 79 years compared with an average of 81.5 years for the other countries. Among developed countries, the Japanese enjoy the highest life expectancy at 84 years. Israel devotes the lowest share of GDP to health care at 7.5%, yet its citizens enjoy a life expectancy of 82 years, as do Icelanders, even though their percentage of GDP spent on health care actually declined from 9.0% in 2000 to 8.7% in 2012.

America has the best-equipped hospitals and most thoroughly trained physicians in the world, spends a higher percentage of GDP on healthcare, yet lags the developed world in life expectancy at birth. That seemed paradoxical: how could other developed countries spend less than 10% of GDP on healthcare yet achieve an average life expectancy at birth 2.6



John J. Dalton

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Table 1 - Changes in Healthcare Share of GDP 2000-2013 and Life Expectancy 1990-2012, 22 OECD Nations

Healthcare % of GDP – 2000 (2)	Healthcare % of GDP – 2013 (2)	% Change	Country	Type of Universal Health Care (1)	Life Expectancy @ Birth, 1990 (3)	Life Expectancy @ Birth, 2012 (3)	Change, Years
9.2	10.1	9.8%	Austria	Insurance Mandate	76	81	5
8.0	10.2	27.5%	Belgium	Insurance Mandate	76	80	4
8.3	10.2	22.9%	Canada	Single Payer	77	82	5
8.1	10.4	28.4%	Denmark	Two-Tier	75	80	5
6.7	8.6	28.4%	Finland	Single Payer	75	81	6
9.5	10.9	14.7%	France	Two-Tier	78	82	4
9.8	11.0	12.2%	Germany	Insurance Mandate	76	81	5
7.2	9.2	27.8%	Greece	Insurance Mandate	77	81	4
9.0	8.7	-3.3%	Iceland	Single Payer	78	82	4
6.8	7.5	10.3%	Israel	Two-Tier	77	82	5
7.6	8.8	15.8%	Italy	Single Payer	77	83	6
7.4	10.2	37.8%	Japan	Single Payer	79	84	5
7.0	11.1	58.6%	Netherlands	Two-Tier	77	81	4
7.5	9.5	26.7%	New Zealand	Two-Tier	76	82	6
7.7	8.9	15.6%	Norway	Single Payer	77	82	5
8.3	9.1	9.6%	Portugal	Single Payer	74	81	7
8.1	8.7	7.4%	Slovenia	Single Payer	74	80	6
6.8	8.8	29.4%	Spain	Single Payer	77	82	5
7.4	11.0	48.6%	Sweden	Single Payer	78	82	4
9.3	11.1	19.4%	Switzerland	Insurance Mandate	78	83	5
6.3	8.5	34.9%	United Kingdom	Single Payer	76	81	5
12.5	16.4	31.2%	United States	None	75	79	4
7.9	9.6	22.0%	21 OECD Nations	Various	76.6	81.6	5.0

1. Modern Healthcare, February 8, 2016, p.34

2. OECD Health Statistics, 2015, FOCUS on Health Spending, July 2015

3. World Health Statistics, 2014, PART III, Global Health Indicators, WHO

years higher than the United States? I decided to delve deeper and grouped the other 21 countries by type of universal health care. I also examined other health indicators. The other indicators that I considered are:

- infant mortality rates (the probability of dying between birth and 1 year of age);
- under-five mortality rates (the probability of dying between 1 year of age and before 5 years of age); and
- adult mortality rate (the probability of dying between 15 and 60 years of age).

As seen in Table 2, Comparison of Changes in Spending and Life Expectancy by Type of Universal Coverage, 22 OECD Nations, the eleven countries with Single Payer systems had the lowest percentage of GDP devoted to health care

(9.2%), less than the percentage of GDP consumed by countries with Insurance Mandate (10.3%) or Two-Tier (9.5%) systems. Moreover, their citizens enjoy an average life expectancy of 81.8 years, the same as or better than countries with other systems, and 2.8 years more than Americans.

A review of adult mortality rates yielded disappointing results (see Table 3, Comparison of Changes in Adult Mortality Rates by Type of Universal Coverage, 22 OECD Nations). America lags the rest of the OECD countries by a substantial margin in its efforts to reduce adult mortality rates for both men and women. While other OECD countries reduced adult male mortality rates by 36.4%, from 141.4 per thousand in 1990 to 83.9 per thousand in 2012, America only attained a 24.9% reduction, from 173.0 per thousand to 130.0 per thousand.

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Table 2 - Comparison of Changes in Spending and Life Expectancy by Type of Universal Coverage, 22 OECD Nations

22 OECD Countries	Type of Universal Health Care (1)	Healthcare % of GDP - 2000 (2)	Healthcare % of GDP - 2013 (2)	% Change	Life Expectancy @ Birth, 1990 (3)	Life Expectancy @ Birth, 2012 (3)	Change, Years
Five Countries	Insurance Mandate	8.7	10.3	18.4%	76.6	81.2	4.6
Eleven Countries	Single Payer	7.6	9.2	21.1%	76.5	81.8	5.3
Five Countries	Two-Tier	7.5	9.5	26.7%	76.6	81.8	5.2
United States	None	12.5	16.4	31.2%	75.0	79.0	4.0
All OECD Nations	Various	8.1	10.0	23.5%	76.5	81.5	5.0

1. Modern Healthcare, February 8, 2016, p. 34
2. OECD Health Statistics, 2015, FOCUS on Health Spending, July 2015
3. World Health Statistics, 2014, PART III, Global Health Indicators, WHO

Table 3 - Comparison of Changes in Adult Mortality Rates by Type of Universal Coverage, 22 OECD Nations

22 OECD Countries	Type of Universal Health Care (1)	Infant Mortality Rate, 2010 (2)	Infant Mortality Rate, 2012 (2)	% Change	Child Mortality Rate, 1990 (2)	Child Mortality Rate, 2012 (2)	% Change
Five Countries	Insurance Mandate	138.6	91.2	-34.2%	68.8	48.0	-30.2%
Eleven Countries	Single Payer	142.3	86.8	-39.0%	68.5	45.6	-33.4%
Five Countries	Two-Tier	136.0	87.2	-35.9%	79.4	51.8	-34.8%
United States	None	173.0	130.0	-24.9%	91.0	77.0	-15.4%
All OECD Nations	Various	141.4	89.9	-36.4%	72.1	49.0	-32.0%

1. Modern Healthcare, February 8, 2016, p. 34
2. World Health Statistics, 2014, PART III, Global Health Indicators

For women, other OECD countries reduced adult mortality rates by 32.0%, from 72.1 per thousand in 1990 to 49.0 per thousand in 2012, while America lagged, attaining a 15.4% reduction, from 72.1 per thousand to 49.0 per thousand. The eleven countries with Single Payer systems achieved the lowest mortality rates for both men (86.8 per thousand) and women (45.6 per thousand).

America’s strong emphasis on prenatal care and the prevalence of well-equipped children’s hospitals should result in low infant and child mortality rates. Wrong again (see Table 4, Comparison of Changes in Infant & Child Mortality Rates by Type of Universal Coverage, 22 OECD Nations). Between 1990 and 2012, OECD countries in the aggregate reduced infant mortality rates by 57.7%, from 7.8 per thousand to 3.3 per thousand, and child mortality rates 56.8%, from 9.5 per thousand to 4.1 per thousand. America only reduced infant mortality rates by 33.3%, from 9.0 per thousand in 1990 to 6.0 per thousand in 2012, and child mortality rates 36.4%, from 11.0 per thousand to 7.0 per thousand. The eleven coun-

tries with Single Payer systems achieved the lowest infant mortality rates (2.9 per thousand) and child mortality rates (3.6 per thousand).

Other studies also place America below other developed countries in health outcomes. For example, The WHO’s “World Health Report 2000” ranked the health systems of its 191 member states based on an index of five factors including financial contribution, disability-adjusted life expectancy, speed of service, protection of privacy, and quality of amenities. France ranked #1, followed by Italy. The United Kingdom was in 18th place and Germany 25th, America ranked 37th, behind Costa Rica and ahead of Slovenia, Cuba and New Zealand. The methodology provoked so much criticism that WHO has not updated the study.

The Commonwealth Fund periodically compares the U.S. healthcare system with those of other developed countries. In its 2014 update (“Mirror, Mirror on the Wall, How the U.S. Health Care System Compares Internationally”), America is last or near last among the 11 nations studied in the report on

Table 4 - Comparison of Changes in Infant & Child Mortality Rates by Type of Universal Coverage, 22 OECD Nations

22 OECD Countries	Type of Universal Health Care (1)	Infant Mortality Rate, 2010 (2)	Infant Mortality Rate, 2012 (2)	% Change	Child Mortality Rate, 1990 (2)	Child Mortality Rate, 2012 (2)	% Change
Five Countries	Insurance Mandate	8.2	3.4	-58.5%	10	4.2	-58.0%
Eleven Countries	Single Payer	7.5	2.9	-61.3%	8.9	3.6	-59.6%
Five Countries	Two-Tier	8	3.4	-57.5%	9.8	4.4	-55.1%
United States	None	9.0	6.0	-33.3%	11.0	7.0	-36.4%
All OECD Nations	Various	7.8	3.3	-57.7%	9.5	4.1	-56.8%

1. Modern Healthcare, February 8, 2016, p. 34

2. World Health Statistics, 2014, PART III, Global Health Indicators

EXHIBIT ES-1. OVERALL RANKING

COUNTRY RANKINGS

- Top 2*
- Middle
- Bottom 2*

											
	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	\$3,800	\$4,522	\$4,118	\$4,495	\$5,099	\$3,182	\$5,669	\$3,925	\$5,643	\$3,405	\$8,508

Notes: * Includes ties. ** Expenditures shown in \$US PPP (purchasing power parity); Australian \$ data are from 2010.

Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund National Scorecard 2011; World Health Organization; and Organization for Economic Cooperation and Development, OECD Health Data, 2013 (Paris: OECD, Nov. 2013).

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dimensions of access, efficiency, and equity (see Exhibit ES-1. Overall Ranking). The countries are listed in alphabetical order from left to right. The United Kingdom ranks first overall, followed closely by Switzerland.

With per capita health spending of \$3,405, the UK ranks first on 9 of 12 factors measured. America ranks last on 4 of 12 factors despite spending \$8,508 per capita, \$5,103 more than the UK. Clearly, American consumers are not getting value for their money.

While other countries have adopted modern health information systems, American physicians and hospitals are playing catch-up, responding to significant financial incentives to adopt and make meaningful use of health information technology. Physicians face particular difficulties in receiving timely information, coordinating care, and dealing with administrative hassles. Implementation of the patient protection provisions of the Affordable Care Act (ACA) already are producing positive results in quality and patient safety. America now ranks in the middle on the quality care factors. Additional ACA provisions should further encourage the efficient organization and delivery of health care, as well as investment in important preventive and population health measures.

Conclusions

- Despite its massive expenditures, the U.S. healthcare system fails to deliver reasonable value for the money, and the gap between the U.S. and other OECD countries on key health indicators is widening.
- The eleven countries with Single Payer systems consume the lowest percentage of GDP on healthcare while achieving the best results on each of the four key health indicators.
- The U.S. also lags OECD countries in studies by the WHO and the Commonwealth Fund.
- Among the eleven countries with Single Payer systems, the Brits do it best.
- It's little comfort, but compared with many emerging market countries (e.g., Brazil, Russia, India, China, etc.), the U.S. attains better results on the four key health indicators.
- ***American healthcare is the worst value in the developed world.***
- It will take a huge paradigm shift to close the gap with other OECD countries on the key health indicators.

Achieving the Institute for Healthcare Improvement's "Triple Aim" will require going well beyond our comfort zones. We already are quite good at diagnosing, treating and curing the patients who receive care in our hospitals. However, improving the health of the population in our service areas will require reaching out into the community's social services safety net to foster better health habits among consumers, something over which hospitals and physicians have little or no control.

Hospitals that succeed in providing better care while improving healthy behaviors in the communities they serve will lower the per capita costs of care and produce better outcomes on the key health indicators.

In rest of this series, we'll explore some underlying reasons for the disparity between America and its OECD counterparts, compare the different approaches taken by France, Germany and the United Kingdom (UK), and conclude with some recommendations for closing the gap.

About the author

John J. Dalton, FHFMA, is Senior Advisor Emeritus at BESLER Consulting, 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. 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.

In addition to serving as Master of Ceremonies at the 40th Annual Institute in October, Mr. Dalton will open the Thursday morning session discussing "American Healthcare – Worst Value in the Developed World."



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