



## Vascular Society of New Jersey

### Monthly Report- June 2011

#### From the President

Paul B. Haser, MD

June has "busted out" as the musical, "Oklahoma," sings it, and your society is now busily engaged in member activities to make your practice of vascular surgery, (including endovascular intervention, vascular medicine, and the vascular laboratory readings), more efficient, profitable and yes, even fun. As part of this format, behind the scene activities include planning for the annual Fall meeting to include spouses/significant others with the invited speaker to be 2008's Nobel Laureate in Chemistry, Martin Chalfie, to speak regarding conceptualization of an amazing scientific experiment, what "translational research" really means, and a world view regarding research.

We continue to work on the web-page and as part of this, are designing a more patient and physician easy access for the members. This also means there will be an effort to collect on delinquent dues, (you know who you are), as well as encourage new members to recognize the substantial value to participation.

Below you will find very important information regarding ambulatory surgery centers, (ASC), what is happening in State government that will impact financially on all citizens, (e.g., school funding and the governor's approval rating), and what the Federal Government has been up to via the Centers for Medicare and Medicaid (CMS), especially in reference to the Accountable Care Organizations (ACO's), the referrals from industry, payment plans to hospitals, four (4) new proposed performance improvement measures, (one of which includes monitoring of central lines), and an End-of-Life Council. And yes, medical marijuana is back in the news too! Lastly you receive well-thought out advice regarding retirement beneficiary naming.

We are all looking forward to the warm weather, busy and successful practices and your continued input into the VSNJ.

#### SAVE THE DATE

**October 27, 2011**

Vascular Society of New Jersey  
Annual Meeting

The Highlawn Pavilion  
West Orange, NJ

#### From the Statehouse

AJ Sabath, Advocacy & Management Group

#### **BILL TO LICENSE ALL ASC ADVANCES IN SENATE COMMITTEE**

Last week, the NJ Senate Health, Human Services and Senior Citizens Committee debated and released legislation, S-2780, which would require licensure of all ambulatory surgery centers. The bill was sponsored by Sen. Joseph Vitale (D-Woodbridge) as a result of recent licensure inspections that proved inadequate and substandard facilities. These inspections have been profiled in the press across the State. Your leadership

and lobbying team have been extremely engaged on your behalf, meeting with all the stakeholders and legislators. We have been working with the sponsors of the bill to educate them on the problems this bill would create, and to remove the taxation provision as well as the onerous physical plant requirements, currently required of all licensed surgery centers. Sen. Vitale agreed to some amendments, specifically exemption from the tax, but the physical plant exemption remains weak (requiring centers to request a waiver from DHSS). We will continue to work with the sponsors, and other legislative leadership to achieve the results needed for our members to continue to practice in their existing safe environments. If you would like to listen to the testimony, you can click on this site, <http://www.njleg.state.nj.us/> Scroll down in the middle of the page to "archived hearings" and click on Senate Health Committee for Thursday, May 26. This was the first bill heard in committee.

Stay tuned for continued updates and additional progress.

### **Senate Judiciary Committee approves Republican Anne Patterson for state Supreme Court**

The Senate Judiciary Committee approved Gov. Chris Christie's nomination of Republican Anne Patterson to the state Supreme Court. If confirmed by the full Democratic-controlled Senate - an action that is now expected - Patterson, 52, of Mendham, will join the high court in September. She is a products liability attorney with Riker, Danzig, Scherer, Hyland & Perretti. Patterson was nominated last May 3 to replace Justice John Wallace, whom Christie declined to reappoint. If renominated by Christie and approved by the upper house, Wallace, 68, the only African-American on the court, would have served two more years before facing mandatory retirement but Christie announced he was nominating Patterson in an attempt to change what he sees as a liberal-leaning court. Senate President Stephen Sweeney (D-Gloucester) refused to act on Patterson's nomination until Wallace term would have expired in 2012. However, he and Christie reached a compromise three weeks ago. Christie nominated Patterson to fill the seat held by Justice Roberto Rivera-Soto, who has said he will not seek renomination when his term expires in September.

### **Education Law Center wins Abbott case**

The latest twist in the long-running Abbott V. Burke school funding case is a recent State Supreme Court ruling that the Christie administration did not fully fund poor-performing students and must spend an additional \$500 million to comply with the state's school funding formula. The court's ruling is not as onerous on the state as some had predicted, requiring the state to increase funding in only the 31 so-called Abbott districts. The total bill would have been \$1.7 billion, but relief was granted limiting funding for the upcoming fiscal year to only the Abbotts. Justice Albin has filed a separate, concurring opinion joining in Justice LaVecchia's remedy and analysis that majority rules in deciding a motion, but expressing the view that there was sufficient credible evidence in the record before the Special Master to affirm a finding that the underfunding of 205 school districts operating below their adequacy budgets, in violation of SFRA, deprived at-risk children of their right to a constitutionally adequate education, and therefore he would order funding at the levels required under SFRA for those 205 districts in the coming school year.

### **Christie's approval rating dips to 40%**

This morning's Fairleigh Dickinson University PublicMind poll shows Gov. Chris Christie with a 40% favorable rating and 45% unfavorable, a reversal from 47% favorable and 41% unfavorable in April; while a third of voters (32%) say the governor is doing a "poor" job, up five points from April. The governor's approval rate is down, with 44% approving and 44% disapproving, a drop from a 51%-41% approval rating in April, and the worst the governor has measured in his term. Moreover, 55% say the state is "on the wrong track," up from 47% in April. Just 36% say the state is headed in the right direction, a decrease of 8 percentage points from April. "A majority (54%) still say the state should cut programs rather than raise taxes, but that number too is down significantly - 10 points from April's measure of 64%. Just one-quarter (25%) say taxes should be raised, unchanged from April, but those who are unsure, or have a mixed opinion or other ideas of how to deal with

the state budget shot up to 22% from 11%. The Fairleigh Dickinson University conducted the poll by telephone, contacting 804 voters with both landline and cell phones from May 16 through May 22, 2011. The poll has a margin of error of +/-3.5 percentage points.

## **LEGAL REPORT**

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### **CMS Announces Initiatives to Encourage ACOs**

CMS has announced two initiatives under the Patient Protection and Affordable Care Act (PPACA) designed to encourage health care providers to establish ACOs. First, the CMS Innovation Center (also created by PPACA) is seeking comments on the idea of an advance payment ACO that would provide additional up-front funding to providers to encourage formation of ACOs. The Innovation Center will also be offering free accelerated development learning sessions to teach providers about coordinating patient care.

CMS is seeking public comments regarding the creation of an advance payment ACO model. This model has been proposed in response to providers' concerns regarding a need for start-up funds to establish an ACO. Under the proposed initiative, eligible organizations could receive an advance on the shared savings they are expected to earn as a monthly payment for each assigned Medicare beneficiary. In order to receive funds, the ACO would need to provide CMS with a plan for how the funds will be used to establish health care coordination capabilities. Any advance payments would be recouped by CMS through the ACO's earned shared savings. Comments to this proposal are due on or before June 17, 2011 and may be submitted electronically to: [advpayACO@cms.hhs.gov](mailto:advpayACO@cms.hhs.gov).

In order to educate providers and executives about essential ACO functions and ways to achieve better care while lowering costs through integrated care models, the Innovation Center will offer four learning sessions. Each session will include a focused curriculum on core competencies for ACO development, such as effectively using health information technology and data resources; building capacity to assume and manage financial risk; and improving care delivery to increase quality while reducing costs. These sessions will not discuss elements of or specific requirements for participation in a CMS ACO program. The first session will be held from June 20-22, 2011 in Minneapolis, MN. Interested persons can register at: <https://acoregister.rti.org>.

### **Genetic Testing Subsidy Gets Green Light from OIG**

A non-profit group (Foundation) seeking to subsidize the cost of genetic testing received a favorable response from the Department of Health & Human Services Offices of Inspector General (OIG). Benefiting from scientific advances linking certain genetic markers with incidences of cancer, many patients are seeking proactive methods of determining their likelihood of developing cancer before symptoms occur or a diagnosis is made. Several of these screening tests are offered by a single source or a limited number of laboratories. Under the proposed arrangement, the Foundation would raise money in order to provide: (1) co-payment assistance to insured financially needy patients seeking genetic testing for cancer; and (2) vouchers for free testing to uninsured patients and those whose insurance does not cover such genetic testing. Under the cost-sharing arrangement, the Foundation will either pay the lab that performs the genetic testing services directly or reimburse the patient upon proof of costs incurred. Under the voucher program, participating laboratories would not bill the patient, and would be reimbursed directly from the Foundation. Medicare recipients would not be eligible for the voucher program (because Medicare beneficiaries are not eligible to receive vouchers).

The Foundation sought an advisory opinion as to whether the arrangement complies with the Federal Anti-Kickback statute (AKS), which makes it a criminal offense to knowingly and willfully offer, pay, solicit or receive remuneration to induce or reward referrals of items or services reimbursed by Medicare. Further, AKS provides for penalties for giving something of value to a Medicare beneficiary that the benefactor knows is likely to influence the selection of a particular provider or supplier of services for which payment may be made by Medicare.

The OIG opined in its written response to the Foundation that donations to the program, and awards granted to beneficiaries from the program, will be permissible because sufficient safeguards are in place such as: (1) the financial donors' inability to control the program; (2) objective criteria are used to approve applications for assistance (including

first come, first served); (3) awards are not based on choice of providers (and patients remain free to choose and change providers); (4) assistance determinations are based on consistent, reasonable, verifiable and uniform measures of financial need; (5) donors are not able to track a correlation between amounts and frequency of donations and amounts and frequency of assistance provided; (6) financial assistance covers the 12 most common genetic tests (subject to expansion upon future scientific development) - with no one test accounting for more than 25% of financial assistance awarded - which avoids steering award recipients to a particular lab or test; and (7) as a tax-exempt organization, the Foundation has an interest in maximizing the scarcity of its resources. Accordingly, the OIG issued an opinion that because the voucher program is not available to Medicare beneficiaries and because sufficient safeguards are in place to administer the cost-sharing program, the foregoing arrangement does not violate AKS.

#### **OIG Questions Referral Company's Proposed Arrangement to Charge Fee for Inclusion in Its Referral Database**

On May 20, 2011, the Department of Health & Human Services Offices of Inspector General (OIG) declined to approve a proposed arrangement whereby a referral company, which receives online referral requests from hospitals, would charge a fee to post-acute care providers to be included in its referral database. The OIG concluded that the proposed arrangement was problematic if the requisite intent to induce referrals were present. In that case, the referral company would be subject to sanctions.

The proposed arrangement raised fraud and abuse concerns because: (1) the referral company would be soliciting and accepting payments in return for the referral company to arrange for the furnishing of post-acute care services payable under the Medicare and Medicaid programs; and (2) because the proposed arrangement otherwise does not satisfy an applicable safe harbor. Even if the referral company allowed post-acute care providers that did not pay a fee to receive hospital referral requests by facsimile, the OIG concluded that this was still problematic because the post-acute care providers that did pay a fee had a competitive advantage in that they would receive referrals instantaneously online. Moreover, the post-acute care providers that did pay a fee would have pressure to recoup its operating costs by, among other things, prolonging patient stays.

For these reasons, the OIG concluded that the proposed arrangement posed a risk of fraud and abuse.

#### **CMS Proposes Changes to FY 2012 Medicare IPPS and PPS**

The Centers for Medicare & Medicaid Services (CMS) recently released its FY 2012 proposed rule, which revises the Medicare hospital inpatient prospective payment system (IPPS) for operating and capital-related costs of acute care hospitals and updates the payment policy and annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals.

In aggregate, Medicare operating payments for IPPS hospital services are projected to decrease by \$498 million in FY 2012 under the proposed rule, a 0.5% decrease from FY 2011 payments. Payments to long-term care hospitals, on the other hand, are expected to increase by 1.9% in FY 2012.

CMS also addressed various quality initiatives in the rule, including proposing to add the following four additional quality measures in FY 2014 for hospitals to report as part of the Hospital Inpatient Quality Reporting Program: (1) central line insertion practice adherence percentage; (2) catheter-associated urinary tract infection; (3) participation in a systematic clinical database registry for general surgery; and (4) Medicare spending per beneficiary. A quality reporting program for long-term care hospitals, as required by the Affordable Care Act, is scheduled to be implemented in FY 2014. CMS proposes that it would require reporting on urinary catheter-associated urinary tract infections, central line catheter-associated blood stream infection, and pressure ulcers that are new or have worsened.

All changes would be applicable to discharges occurring on or after October 1, 2011. Written comments on the proposed rule are being accepted by the CMS through June 20, 2011.

#### **Proposed Legislation Requiring Surgical Practices to be Licensed Heads to Full Senate for Consideration**

Legislation that was introduced in March in the New Jersey Legislature, requiring surgical practices to be licensed by the New Jersey Department of Health and Senior Services (DHSS) as ambulatory care facilities, was recently voted out of the

Senate Health, Human Services and Senior Citizens Committee and now heads to the full Senate for consideration. Under the current "Codey Law," surgical practices are not required to be licensed. Instead, they must register with the DHSS and obtain either certification by the Centers for Medicare & Medicaid Services (CMS) as an ambulatory surgery provider or ambulatory care accreditation from an accrediting body recognized by CMS.

This bill, S2780, would repeal the registration requirement and instead mandate that all surgical practices be licensed by the DHSS as ambulatory care facilities within one year of its enactment. Committee amendments were offered to the original version of the legislation that would exempt these newly licensed facilities from having to pay the ambulatory care facility assessment and would permit waivers of certain physical plant requirements mandated under licensure standards. Existing surgical practices are not otherwise grandfathered under the current version of the bill.

The bill's counterpart in the Assembly, A4099, has been referred to the Assembly Health and Senior Services Committee.

### **Most Medicaid Services Switching to Mandatory Managed Care**

Effective July 1, 2011, individuals who were previously exempt from enrollment in New Jersey Medicaid and NJ FamilyCare managed care programs will be required to be enrolled in one of the four New Jersey Medicaid HMOs. In addition, individuals dually eligible for Medicaid and Medicare, those in a waiver program, or those who were otherwise excluded from managed care must be enrolled in the fall. Individuals who do not choose an HMO by July 1, 2011, will be randomly assigned to one.

Care will be coordinated by the member's HMO and the member will be required to use providers that are in each HMO's network. However, the State will allow a period of time of care with existing services and providers until each HMO can assess the member and implement alternate plans of care, as appropriate.

In addition, certain services that have previously been provided under the fee for service Medicaid program will now be provided by a Medicaid HMO. These services include home health care, pharmacy benefits, personal care assistants, physical therapy, occupation therapy, speech therapy, and adult and pediatric medical day care services.

The four Medicaid HMOs are: (1) Amerigroup, New Jersey, Inc. (all counties, except Salem); (2) Healthfirst Health Plan of New Jersey (Bergen, Essex Hudson, Mercer, Middlesex, Morris, Passaic, Somerset, Sussex and Union counties); (3) Horizon NJ Health (all counties); and (4) United Healthcare Community Plan (all counties).

Providers not in a Medicaid HMO network may continue to provide care until the member is assessed by their HMO and a new care plan is put into place. After that, providers who wish to continue to provide services to Medicaid beneficiaries will be required to apply to be a participating provider in one or more of the Medicaid HMOs. All claims submitted after July 1, 2011, (or the fall, as applicable), must be submitted to the member's Medicaid HMO, which will handle the continuation of care claims as well as claims for services provided by its network of providers.

### **Proposed New Jersey Legislation Would Require Certificate of Need Review For Hospital-Based Obstetric and Pediatric Services**

On May 26, 2011, the Senate Health, Human Services and Senior Citizens Committee approved a bill that would require hospital-based obstetric and pediatric services to go through the state's Certificate of Need (CN) review process (S2867). The bill now heads to the Senate floor for consideration.

A CN was required for hospital-based obstetric and pediatric services prior to an exemption granted from such requirements in 1998. This bill would reinstate the CN requirement. Committee amendments narrowed the bill's scope so that CN review would not be required for the addition of basic obstetric and pediatric beds in hospitals and the elimination of fewer than fifty percent of basic obstetric and pediatric beds in hospitals.

Opponents of the bill cite the amount of time and considerable added expense as the principal deterrent to the CN requirement. In addition, many believe that the CN process should be expedited to facilitate mergers and facility closures.

### **Medical Marijuana Operators Sue Federal Government over Civil Rights Violations**

In response to recent crackdowns by the U.S. Department of Justice (DOJ), two Montana medical marijuana providers have filed suit against the U.S. government, alleging that the raids on their facilities were unconstitutional, exceeded the government's authority and were pre-empted by their state's medical marijuana law.

The DOJ previously indicated to states across the country that although patients legally using a state's medical marijuana program would likely not be subject to civil suits or criminal prosecution, blanket immunity would not be provided to program operators. As a result, New Jersey Attorney General Paula Dow sent a letter in April to U.S. Attorney General Eric Holder requesting guidance as to the enforcement position of the DOJ with respect to New Jersey's medical marijuana program. Dow has indicated that she sent a follow-up letter to the DOJ on May 23, 2011, but the DOJ has yet to respond to either letter.

### **New Jersey Senate Approves Bill Establishing End-of-Life Council**

On May 26, 2011, the Senate Health, Human Services and Senior Citizens Committee approved a bill that would establish an Advisory Council on End-of-Life Care (S2199). The bill now moves to the full Senate for consideration. The Council would consist of several members, including: the Commissioners of Health and Senior Services and Human Services, or their designees; two members each from the Senate and General Assembly; a representative of hospice care; two physicians specializing in pain management or end-of-life care; two representatives of general hospitals, a representative of nursing homes; a registered professional nurse; an attorney; a patient advocate; two members of the general public; one person serving on behalf of individuals with mental illness; one person serving on behalf of those with developmental disabilities; and an academic with expertise in bioethics.

The Council's goal would be to conduct a comprehensive study relating to the quality and cost-effectiveness of, and access to, end-of-life care services for New Jersey residents. The Council will develop policy recommendations for end-of-life care that prioritize patients' wishes and ensure that patients are provided with dignified and respectful medical treatment that seeks to alleviate pain as much as possible. These recommendations would be reported to the Governor and the Legislature within 18 months of the Council's organization.

## **ASSET PROTECTION STRATEGIES**

### **401(k) rights trumped by ERISA**

In a recent case (*Cajun Industries v. Kidder, et al*), the court ruled that despite having previously named his 3 children as beneficiaries of his 401(k) plan, a deceased plan participant's 401(k) balance will pass to his new wife. The court determined that under the terms of the plan, a spouse's right to plan assets is immediately vested upon marriage, and since no spousal waiver was obtained, the default beneficiary is the spouse, even though she was not the named beneficiary.

The spouse got the 401(k), and the children, who were the intended beneficiaries, were disinherited.

Normally, when it comes to retirement accounts, the beneficiary form is the most important document there is.

It takes precedence over prenuptial and postnuptial agreements and even contrary instructions contained in your will. But the *Kidder* case makes it clear that when it comes to ERISA plans, the beneficiary form can be trumped by spousal rights.

The court's ruling will affect all ERISA plans including 401(k)s, profit sharing plans, money purchase plans, defined benefit plans, and some 403(b) plans.

As a result of this ruling I would strongly urge you to review your current beneficiary arrangements on all of your retirement plans. For those of you who have a living spouse, and wish to name your children (or any other non-spouse) as a beneficiary, you will need to make sure that you have a signed spousal consent form on record. If you have any questions please contact me at [dvargo@varbeco.com](mailto:dvargo@varbeco.com) or (877)972-7900.

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