NJHCFFA
NEW JERSEY HEALTH CARE FACILITIES FINANCING AUTHORITY

AUTHORITY NOTE$

2018 Series B **SUMMER**

From the Executive Director

Summers are great for many reasons. The warm weather, the longer days and vacations all create a more relaxing atmosphere than other seasons of the year. The Authority however is using this respite to make financing even easier for you.

At the July 26, 2018 Authority meeting, the Members approved a policy change to streamline the approval process for new money bonds. Until now, we have required three (3) meetings to obtain approval for a contingent bond sale: an initial meeting to consider a negotiated sale request; a second meeting to receive an informational presentation on the project and financial projections; and a third meeting to consider the contingent bond sale request.

After consulting with borrowers, we believe that by eliminating one meeting, we can reduce the time it takes to get bonds to market and therefore, avoid the chance of any significant market fluctuations. Under the new process, the informational presentation on the

(continued on page 2)

Moving Toward Value-Based Health Care … Albeit Slowly

Value-based health care is one of the critical components to achieving the ultimate goal of population health. Under the value-based care model, the patient's overall health is the primary focus rather than the treatments of various symptoms. It requires the coordination of the providers to ensure that proper care is provided at the right time. And, it may necessitate the collaboration of several providers to eliminate duplicative tests or gaps in treatment. The objective is to get and keep an individual healthy, thereby improving the general health of the population and eventually lowering health care costs.

There are additional benefits of value-based care. First and foremost, patients will spend less money on healthcare. Value-based care places the focus on preventing chronic disease and reducing recovery times from illness and injuries. The result will be fewer doctor visits, hospital stays, tests and prescription drugs. The patient spends less!

The providers also realize benefits. Value-based care emphasizes the quality of services. Physicians are encouraged to devote more time to a patient's primary care and disease prevention. The goal is to have physicians spend much less time managing their patients' chronic diseases.

Of course change is always difficult. This is particularly the case when you are talking about dramatically altering the way providers will get paid. Under the long established fee-for-service payment model, health care providers are paid for each service they provide. As a result, the incentive is for the providers to perform as many services as possible. The value-based model, however, rewards the quality of care and improved outcomes. Understandably, the providers are concerned about how much they will get paid as well as how the payments will be determined.

In the US, there is one common denominator in health care, the Centers for Medicare & Medicaid Services (CMS.) CMS touches nearly every health care provider across the country. In order to initiate any change to national health care, it must start with CMS.

CMS has taken the lead in transitioning the country to value-based care and, logically, it started with their

(continued on page 3)

(continued from page 1)

project and financial projections will take place at the first meeting with the negotiated sale presentation (if requested.) The Authority staff may, due to unforeseen circumstances, allow the informational presentation to occur at the meeting when the contingent bond sale is considered.

We believe that our staff will still have ample time to properly vet the project and analyze the financial data from the borrower. Our goal is to be more efficient in responding to our borrowers.

In a similar vein, I want to remind all of you of the Authority's Capital Asset Program. The Authority has a "revolving pool" of $50 million dollars waiting to lend you. If you need to finance or refinance major moveable equipment, bridge loans, existing renovations or minor construction, the Authority is here for you. Using standardized forms and direct negotiations between the buyer and credit enhancer, loan applications are approved quickly. And, there is only a $500 issuance fee.

Similarly, as technology advances, you may want to consider our Equipment Revenue Note (ERN.) If you need updated equipment or enhanced technology, the ERN provides quick access to a maximum of $60 million.

Whether your financial needs are great or small, we have the programs and the streamlined processes to expedite your requests.

- Mark E. Hopkins

The Authority Announces a New, Streamlined Approval Process

At the July 26, 2018 Authority meeting, the Members approved reducing the number of Authority meetings required to approve new money bonds from three (3) meetings to two (2) meetings. The Authority believes that this move will benefit borrowers by shortening the time between the request and taking the bonds to market, thereby reducing the chance of any significant market fluctuation.

The new process, however, will require the borrower to make an informational presentation - including the project description and financial projections - at the first meeting. This will provide the Authority with the time to properly vet the project and the financing. Under certain circumstances, the Authority may allow the borrower to make the presentation at the second meeting, prior to the consideration of the contingent bond sale.

Happy Anniversary!

Senior Asst. Account Administrator Diane Johnson celebrated 25 years at the Authority on May 24, 2018

Designee for the Commissioner of Health

Commissioner Shereef Elnahal, MD appointed **Robin C. Ford** as his designee to the Authority. Ms. Ford serves as the Executive Director of the Office of Health Care Financing. Ms. Ford holds a Bachelor's and Master's degrees from Rutgers.

Welcome

Alpa Patel was recently hired as the Authority's new Controller. Ms. Patel was previously a Staff Accountant at MOL (America), a Fund Accountant at the ZAIS Group and a Financial Analyst at Jeffries & Co. She received her Bachelor's degree from Rutgers and a Masters in Accounting from Fairleigh Dickenson.

(continued from page 1)
reimbursement policies. The initial value-based programs developed by CMS were accountable care organizations (ACOs), bundled payments and patient-centered medical homes. An ACO is a network of physicians, hospitals and other providers organized to provide coordinated, high quality care to Medicare recipients. Their goal is to eliminate unnecessary or duplicate tests and procedures and reduce medical errors. The providers in the ACO share in the savings realized from lowering the overall cost of treating a patient.

Under the bundled payment program, the entire treatment episode is paid for at a rate set by historical prices. If the providers are able to reduce any of the costs, they keep the difference.

Finally, CMS instituted the Patient-Centered Medical Home (PCMH.) In this program, all of the patient's care is coordinated through their primary physician. The increased one-on-one attention by physicians allows for more effective preventative medicine and accurate diagnoses. Recently, a PCMH in Colorado reported a 15% drop in emergency room visits and an 18% reduction of inpatient admissions.

To further facilitate the transition to value-based care, CMS added additional programs: Hospital Value-Based Purchasing Program; Hospital Readmission Reduction Program; Physician Value-Based Modifier; and Hospital Acquired Conditions Program. Additionally, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) provides a framework for value-based health care. Unfortunately, CMS acknowledged that only 20% of the 2015 Medicare payments were made to through a value-based model. However, a Humana study revealed that, in 2017, commercial payers reported that 24% of their payments were to value-based mechanisms. They also projected that number to increase to 50% by the end of 2018.

Obviously, many health care providers have yet to come on board. Quest Diagnostics surveyed health plan executives and physicians on their value-based care efforts. Only 57% of the respondents believed that they had the tools necessary to provide value-based care. Other concerns expressed were: not having sufficient information about their patients; the non-interoperability of Electronic Health Records (EHR) with other technological tools; the need to improve existing technology; and a conflict between payer and provider over the value of metrics in determining a course of treatment or preventative medicine strategies.

On the positive side, the Humana study indicated that 74% of health care executives saw positive financial results in their value-based efforts. Moreover, physicians see the benefits to the increased patient engagement and are hopeful that the value-based trend will spur technological improvements. Making the EHR systems less time-consuming for physicians and enabling interoperability are at the top of their list. Additionally, both the payers and providers believe that the progress being made in the areas of bioinformatics, artificial intelligence and machine learning will get us there faster.

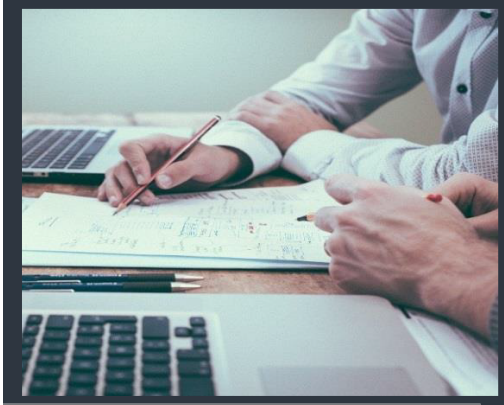
Value-based care has come a long way in a relatively short period of time. While the cursory review by the Health Financial Management Association indicates that the projected cost savings of value-based programs have not been realized, they also note that there were limited programs from which to draw data. They also cited that the lack of financial incentives in the evolving model and reluctance to embrace change also played roles.

Despite the above, there are reasons for optimism. Value-based models are rising in popularity. UnitedHealth Group is projecting that 150 million Americans will be in value-based care programs by 2025. Likewise, a Change Healthcare survey found that 120 payers will be moving to value-based care models.

Value-based care has survived its growing pains and is taking a pragmatic approach in addressing the concerns. It may be taking longer than anticipated, but that appears to be reflective of the magnitude of the task rather than industry resistance.

It is said that anything worthwhile is worth waiting for and value-based care and population health will be the US health care standard, hopefully sooner rather than later. ⌘

simplify your financing



NEW JERSEY HEALH CARE FACILITIES FINANCING AUTHORITY
CAPITAL ASSET PROGRAM

The **Capital Asset Program ("CAP")** is a "revolving pool" of $50 million which is available to make loans to health care facilities wishing to finance or refinance major moveable equipment, renovations to existing plants, minor construction and additions, parking garages and bridge financing. The **CAP** was designed to take advantage of bonds issued prior to the 1986 tax law changes. Loans made under the **CAP** are continuously repaid, making fresh funds available for other borrowers. Because program costs are shared and the program benefits from variable interest rates backed by an "Aa" rated letter of credit, the effective interest rate goes down as more borrowers participate.

SIMPLE BENEFITS OF THE PROGRAM

- Quickly approved loan applications
- Straightforward, uncomplicated terms negotiated directly between the borrower and the credit enhancer
- Security provided through equipment liens or master indenture notes
- No required arbitrage rebate
- Available funds for certain "bad money" uses
- Standardized documents to cut time and reduce fees

*Take advantage of this unique loan program, with an issuance fee of only **$500**, today!*

NJHCFFA
NEW JERSEY HEALTH CARE FACILITIES FINANCING AUTHORITY

Contact us for more information:
Jessica Lucas
Capital Asset Program Manager
jlucas@njhcffa.com
(609) 789-5639

NJHCFFA

NJHCFFA MEMBERS

Ex-Officio Members
Dr. Shereef Elnahal
Commissioner of Health

Carole Johnson
Commissioner of Human Services

Marlene Caride, Esq.
Commissioner of Banking & Insurance

Public Members
Suzette T. Rodriguez, Esq.
Munr Kazmir, M.D.

The Authority currently has two Public Member vacancies.

NJHCFFA SENIOR STAFF

Mark E. Hopkins
Executive Director

Frank Troy
Director, Division of Research, Investor Relations & Compliance

Ron Marmelstein
Director, Division of Operations, Finance & Special Projects

William McLaughlin
Director, Division of Project Management

New Jersey Health Care Facilities Financing Authority

Mailing Address:	P.O. Box 366 Trenton, NJ 08625-0366
Delivery Address:	22 South Clinton Avenue Trenton, NJ 08609-1212
Telephone:	609.292.8585
Fax:	609.633.7778
Web:	www.njhcffa.com