Watchdog Group Sues State Over Nursing Home ‘Patient Dumping’

Group claims state not protecting patients

A nursing home watchdog group filed a lawsuit that claims California state health agencies are not doing enough to discourage alleged “patient dumping” at nursing homes and skilled nursing facilities.

The lawsuit filed November 9 in U.S. District Court in San Francisco by California Advocates for Nursing Home Reform names California Health & Human Services Agency Secretary Diana Dooley as a defendant. The lawsuit alleges that Dooley and the HHS are “willfully violating federal laws” by not enforcing laws to stop California nursing homes from dumping patients.

The lawsuit claims that patient dumping is an “epidemic” in nursing homes and skilled nursing facilities in California because of low Medi-Cal reimbursements rates. “When a resident’s ability to pay comes exclusively from Medi-Cal, which is often the case, a facility has a strong financial motivation to get rid of that resident and replace him or her with a private pay resident,” the lawsuit states. The complaint contends that nursing facilities “can receive up to $500 per day” for non-Medi-Cal patients while the flat fee paid for Medi-Cal patients is only $190 per day.

California Advocates for Nursing Home Reform Executive Director Patricia McGinnis said the group has been lobbying state agencies for years to take action against patient dumping. “They are very aware that it’s happening,” said McGinnis. “We’ve met with Secretary Dooley and other state agencies several times and this summer it finally came to a head.”

McGinnis said the lawsuit was filed in the wake of several incidents of alleged patient dumping at nursing homes in 2015. One incident mentioned in the lawsuit alleges that John Wilson, a former resident at St. John’s Valley sub-acute skilled nursing unit, won a readmission hearing to the facility on June 26 but that St. John’s has “refused to comply with the DHCS [state Department of Health Care Services] readmission hearing order.” St. John’s could not be reached for comment.

Federal law requires states to offer patients a readmission hearing if they are not allowed to return to a nursing home after a hospital stay but the lawsuit contends the state is not enforcing the readmission orders.
Watchdog Group cont.

The lawsuit also alleges that Wilson has been "warehoused at St. Johns Valley Hospital" for nearly five months and is "one of thousands of residents who have been dumped in hospitals throughout the state." The lawsuit contends that incidents of so-called "hospital dumping" are common and involve a facility sending a patient to the hospital and then refusing to take him or her back after being discharged.

McGinnis said that California Advocates for Nursing Home Reform has been pushing the state to become more proactive to prevent patient dumping by making stricter penalties. " [Not readmitting a patient] is currently punished with a fine of $1,000," said McGinnis. "A $1,000 fine is not going to discourage a facility from doing this."

The California Department of Public Health and California HHS declined to comment on the case, citing a state policy to not comment on pending litigation. The California Association of Health Facilities (CAHF), a group that represents nursing homes and skilled nursing facilities in the state, said it objects to allegations in the lawsuit.

"We strongly object to any allegations that patient admissions are tied to payment sources, since most residents (two-thirds) are on Medi-Cal," said CAHF director of public affairs Deborah Pacyna. "Nursing homes have to hold a bed for seven days if a patient is admitted to the hospital, but after that, the regulations say an admission can be denied if the patient is a danger to himself or others." Pacyna said one incident mentioned in the lawsuit involved a patient who "attacked and injured a fellow resident" and then attacked three police officers who responded to the incident. "This isn't about patient dumping. It's about patient safety."—DOUG DESJARDINS

Study Shows Demographics Influence Vaccine Exemption Rates

White, affluent parents more likely to request exemptions

A new study found that white parents who live in more affluent areas of California were more likely to seek personal belief exemptions for childhood vaccinations in 2013.

The study published in the November issue of the American Journal of Public Health looked at personal belief exemption rates in the state in 2013 when 3.03% of parents were granted personal belief exemptions (PBEs) to opt-out of having their children vaccinated for diseases such as whooping cough and measles. The study then looked at how rates broke down by demographics such as ethnicity and income levels.

CONTINUED ON PAGE 3
building across the street but that the facility is also on schedule to open in 2018. "Timing is on track," said Browner. The medical office building and the new California Pacific Medical Center campus will be linked by a pedestrian tunnel under Van Ness Avenue. A separate, $600 million project to rebuild 120-bed St. Luke's Hospital is also on schedule to open in 2019.

Kaiser Permanente reached a tentative contract settlement with about 1,400 mental health workers and averted a planned strike that was scheduled for November 16. According to a November 16 report in the Marin Independent Journal, Kaiser and mental health workers represented by the National Union of Healthcare Workers (NUHW) reached a tentative, three-year agreement that will be voted on by union members in the coming weeks. Union members had been without a contract for four years and went on a weeklong strike earlier this year. "Kaiser has opened the door to a positive working relationship with us with the goal of providing timely, quality care to our patients ..." said Clement Papazian, union president for the NUHW's Northern California chapter. "It's a positive first step."

Former California state senator Darrell Steinberg acted as a mediator for the talks between Kaiser and the union.

Sutter Health Plus has formed a partnership with LISI, Inc., a general agency that serves the health insurance broker community in California.

"Many commentators have said that white, more-educated parents are among the primary drivers of the trend of parents increasingly seeking personal belief exemptions," said study lead author Y. Tony Yang, an associate professor at George Mason University.

The study found that white parents with higher incomes were more likely to request personal belief exemptions for their children. In terms of income, the study noted that "the effect of moving from the 10th percentile to the 90th percentile in observations of income (from $25,000 to $135,000) was 1 additional PBE per 116 students in 2013." It also noted that "a similar move for race (from 5% to 85% White) was associated with a 2.66% increase in PBE, or one additional PBE per 38 students."

But the study determined that higher education levels had a negligible impact on PBEs, noting that "educational attainment did not independently predict 2013 PBEs." It found that a 10% increase in the percentage of college degrees among parents corresponded with .025 decrease in PBEs in 2013.

Yang said researchers are currently working on a similar study in another state. He added that the findings "underscore the potential value of a targeted, tailored approach to messaging about the importance and safety of vaccines" to discourage PBEs among parents and that public information campaigns could "focus on select communities" where PBEs are typically higher than average.

Among other findings in the study, PBEs among students in private schools were 5.43% in 2013, nearly double the 2.88% average in public schools. It also found that nearly 25% of individual schools in California had measles vaccination rates that were below the 92% to 94% ratio recommended to maintain 'herd immunity.'

A similar study on PBEs conducted by Emory University in the wake of the 2010 whooping cough epidemic in California also determined that more affluent communities had higher rates of PBEs. In addition, the 2013 study found that those communities had higher rates of whooping cough during the epidemic because fewer children were vaccinated against the disease.

Legislation approved in June will eliminate nearly all personal belief exemptions in California beginning in July 2016. Senate Bill 277 authored by Richard Pan (D-Sacramento) and Ben Allen (D-Redondo Beach) will require that parents show proof that children have been vaccinated for diseases such as measles and whooping cough before they enter school next year. The bill has several exemptions that include children in private home school programs not having to be vaccinated.—DOUG DESJARDINS
Decision on Daughters of Charity Deal Postponed Until December

Attorney general to issue decision by Dec. 3

The state attorney general has postponed a decision on whether to approve an affiliation deal between the Daughters of Charity Health System (DCHS) and BlueMountain Capital Management.

State Attorney General Kamala Harris was scheduled to issue a decision by Nov. 19 but will now wait until Dec. 3. Rachele Huennekens, a spokesperson for the attorney general, said the decision was postponed to give the attorney general’s office additional time to consider one of the largest health system deals in state history.

“The reason for the extension is that this is the largest nonprofit hospital transaction in the history of the state of California and our office wants to give it the careful consideration it merits,” said Ford.

DCHS said in a statement that it has no problem with the extension and said the health system will “continue to work closely with all parties” and remains confident that the affiliation deal will be “successfully completed on this new timeline.”

Under terms of the agreement, a division of BlueMountain called Integrity Healthcare "will provide key management services and day-to-day operational support" while BlueMountain will provide $250 million in capital to allow DCHS to "repay certain outstanding obligations, provide operational liquidity, and invest in physical plant improvements and operations." BlueMountain will also assume all collective bargaining agreements with hospital unions and all pension and retirement plans for DCHS employees.

The management team for Integrity Health includes Mitch Creem and Mark Meyers. Creem has 33 years of experience in the healthcare industry including stints at Keck Hospital of USC and the UCLA Health System. Meyers has 22 years of experience as a hospital executive including stops at Dignity Health and Glendale Memorial Hospital.

The DCHS system includes St. Vincent Medical Center in Los Angeles, St. Francis Medical Center in Lynnwood, O’Connor Hospital in San Jose, Saint Louise Regional Hospital in Gilroy, Seton Medical Center in Daly City, and Seton Coastside in Moss Beach. The system also includes the DCHS Medical Foundation.

In early 2015, Daughters of Charity announced that it was interested in teaming up with a larger partner. DCHS entered negotiations with several potential buyers before settling on an acquisition deal with Prime Healthcare Services. But that agreement fell apart in April when Prime balked at conditions imposed by the attorney general in her decision to approve the sale. The conditions included keeping five of six DCHS hospitals open for at least 10 years.—DOUG DESJARDINS
voted to unionize for collective bargaining. According to a November 13 report in the Santa Cruz Sentinel, employees will be represented by the Service Employees International Union-Healthcare Workers West (SEIU-UHW). The vote affects about 120 employees including medical assistants, registered nurses, physical therapists, and social workers. A statement from the Dignity Health Medical Foundation said that, ‘Dignity Health respects our employees’ decision and will work in good faith with SEIU union representatives to reach an agreement on a contract covering the new local.”

**L.A. Care Health Plan** received a three-year contract worth $10.8 million to help 2,165 providers in Los Angeles County achieve meaningful use of electronic health records (EHRs). The award was granted through the state Department of Health Care Services to L.A. Care’s Health Information Technology Extension Center-Los Angeles County (HITEC-LA). "This award is critical to leveling the playing field for many of our Medi-Cal providers and we're thrilled to help them improve their capabilities to better serve L.A. County patients,” said L.A. Care CEO John Baackes. HITEC-LA was founded in 2010 to help providers in Los Angeles County adopt EHR systems and use them to achieve federal standards for meaningful use. Meeting meaningful use standards makes providers eligible for incentive payments for Medicare and Medi-Cal patients.

The Department of Veterans Affairs has named Stephen Bauman as the new director of the VA Central California Health Care System in Fresno. Bauman will oversee an operating budget of more than $210 million and manage the healthcare of nearly 96,000 veterans in the region. "We are excited to bring Stephen Bauman on board as the new director of the VA Central California Health Care System,” said Sheila Cullen, director of the Veterans Integrated Service Network 21. "His sound leadership qualities and proven experience will be invaluable assets for the facility.” Bauman began his VA career in 1977 and most recently served as the deputy network director for the VA Sierra Pacific Network in Vallejo. VA Central California includes a 57-bed acute care hospital and a 54-bed community living center.

The annual ‘Top Performer on Key Quality Measures®’ list from The Joint Commission includes 95 hospitals in California. More than 300 hospitals in California submitted data for the list that rates hospitals on 10 measures including patient care for pneumonia, heart failure, stroke care, and surgical care. The 10 California hospitals that made the list for 2014 and the four previous years include Encino Hospital Medical Center, Garden Grove Hospital Medical Center, Kaiser Foundation Hospital - South Bay, Huntington Beach Hospital, La Plama Intercommunity Hospital, Memorial Hospital Los Banos, Prime Healthcare Paradise Valley Hospital Prime Healthcare Services - Shasta, Sutter Maternity & Surgery Center of Santa Cruz, and Kaiser Foundation Hospital - South San Francisco.
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To qualify for this unique opportunity, you must be a CA licensed RN with at least five to seven years’ acute care nursing experience including at least three years of recent leadership experience in a clinical care environment. Importantly, two years of upper management experience in a hospital system or in primary/specialty care clinics is required with a demonstrable record of success in these endeavors. A BSN or Master’s degree in Nursing, Public Health or other related field is necessary. A Public Health Nursing Certificate is preferred but is required within 24 months of employment. Prior public health experience is a plus. Our ideal candidate will be able to move seamlessly between the boardroom and the clinical environment; strong organizational and strategic abilities will round out your skill set.

About Redlands Community Hospital: we are a 229-bed facility located in Southern California, mid-way between Los Angeles and Palm Springs. We’ve been providing quality healthcare to our neighbors in Redlands and surrounding communities since 1904. Now in our second century of service, we have grown to more than 270 board certified physicians, 100 health plans, 1400 employees, and 300 volunteers.

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Conduct contract reviews to analyze rates, language; ensure timely negotiations. Evaluate new contract proposals from payers. Respond to all correspondence and inquiries in timely manner. Clearly communicate proposed contract language changes to payer according to departmental procedure on preferred terms, conditions. Prepare detailed reimbursement analysis including CPT code specific comparison and weighted average comparisons using local and/or statewide coding frequency; analyze changes in contract rates, expected payments based on contract rates and actual payments. Coordinate with business development and acquisition departments to conduct and complete due diligence for acquisitions. Evaluate managed care environment in each assigned market for development of contracting tactics/strategy, become familiar with state/local laws regarding contracting, collections and other issues. Understand contracts with hospitals for medical directorships, stipends, unit management, or hospital privileges and implications for payor contracting. Assess value and pros/cons of participation in IPAs, PHOs, and other physician organizations. Supervise Managed Care Specialists.

Education and/or Experience:

Bachelor’s Degree in related field. 5 years with health insurance, patient accounting and/or managed care including payer or provider contracting background. Experience negotiating managed care contracts with third party payers regarding physician professional service compensation issues; Experience with fee schedule, case rate, per diem, and capitation reimbursement; familiar with patient accounting tasks including billing, collections, and reimbursement analysis. Ability to prioritize jobs duties, meet deadlines and effectively work on many tasks at one time. Occasional travel.

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Qualifications include:

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- Care delivery and strong program operations experience strongly preferred.
- A Bachelor’s degree in business administration, economics, health care administration, operations research, public health administration, or other related field.
- A Master’s degree is strongly preferred.
- The ability to determine the key business issues and develop appropriate action plans from multidisciplinary perspectives
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✔ Claims Analyst II
✔ Accounts Payable/Payroll Specialist
✔ Director, Government Relations
✔ Executive Administrative Assistant
✔ Manager, Claims Transaction
✔ Member Services Quality Auditor
✔ Clinical Operations Assistant

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Network Contract Manager
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Responsible for the management of IEHP’s general accounting and financial reporting department. Manages the monthly financial statement close process and internal reporting in accordance with generally accepted accounting principles (GAAP), reviews the month-end work papers and journal entries prepared by the accounting team for accuracy and completeness, prepares financial reports and assists in presenting findings and recommendations to CFO.

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- LVN, Case Manager (Seaside Health)
- FOA Supervisor
- Limited X-Ray/MA

OPERATIONS
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- Manager, Material Services
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- Lead, Payroll
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- Complex Nurse Specialist
- FOA Team Lead
- Sonographer

- Case Manager P/T & Per Diem
- Manager, Coding Compliance
- Insurance Billing Specialist
- Supervisor, Credentialing
- Medical Management Coord. (Seaside)
- Training Specialist Coordinator Clinical

- Business Systems Specialist (Tapestry)
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This position reports to the Sr. Director of Care Management. Current unrestricted California RN License; BSN required and Masters Degree in Nursing preferred or comparable experience. Possession of a valid California Drivers license and valid automobile insurance. CCM certification a plus. At least three to five years as a registered nurse in a clinical setting; and at least 5 years progressively responsible experience in Care Management in a managed care setting. Operational knowledge of computer applications in an office environment. Knowledge of CMSA professional standards.

**DIRECTOR PROCESS IMPROVEMENT**

Bachelor’s degree required, preferably with an emphasis in a Technical Science or Engineering. Masters degree in Public or Business Administration preferred. Certified Professional in Healthcare Quality preferred. Certified Lean Six Sigma Black Belt or Master Black Belt preferred. Minimum of ten (10) years performance management and quality improvement experience with an emphasis on Lean/Six Sigma methodologies required. Proven skills adapting and applying Lean Six Sigma methodologies, performance management and quality improvement in a public health setting. Demonstrated understanding of business principles, strategy, technology processes and operations with an inherent ability to apply technology in solving business problems. Strong leadership, communication, written and interpersonal skills to execute and manage activities in a fast paced environment. Ability to establish and maintain effective working relationships at all levels within the organization.

Ability to exercise discretion and independent judgment, make decisions and must possess strong analytical skills. Ability to influence management and create positive change, as well as gather data, perform analysis, recommend courses of action for greater productivity independently. Must have ability to perform research and analysis in support of company inquiries and modify and enhance the modeling effort to accommodate new processes, procedures, products and services. Position requires an individual who is extremely organized with excellent written and verbal communication skills and ability to establish and maintain effective working relationships. Must have the ability to model concepts and to access and manipulate data through self-system access and personal analysis.

**QUALITY ASSURANCE NURSE RN/LVN – COMPLIANCE**

Bachelor’s degree preferred. Education requirement may be waived if candidate has extensive supervisory and operational experience in a medical claims payer environment. Five (5) years of medical claim operations experience with at least three (3) years in a related supervisory capacity. Compliance audit experience preferred. Extensive experience writing policies & procedures and training documentation. Highly organized with the ability to balance multiple projects and meet deadlines. Strong presentation skills. Ability to transform concepts into business operations. Experience in a Lean strategy environment highly desired.

Solid understanding of Medi-Cal and Medicare rules and regulations governing claims adjudication practices and procedures preferred. Demonstrated business training principles and techniques. Analytical skills with emphasis on time management, quality statistics, and problem solving. Strong writing, organizational, project management, presentation and communication skills required. Must have a high degree of patience, excellent interpersonal/communication skills.

**ACCOUNTING SUPERVISOR**

Requires a Bachelor’s degree in Accounting/Finance. Five (5) years experience in accounting and financial reporting. Experience in supervising other staff members. Healthcare experience preferred. Must have the ability to use financial software, with knowledge of relational databases helpful.

Supervise Accounting Coordinators and Accounts Payable. Perform cash management functions, reconcile GL accounts, prepare management reports, monitor functions for compliance to internal controls, resolve all hardware and software problems for supervised functions, analyze reports and accounts for variance analysis. Assist with year-end audits, identify and formulate process improvement projects.

**FINANCIAL ANALYST**

Bachelor’s degree required. Minimum three (3) years of Finance experience. Experience and knowledge of complicated budgets preparation and budget to actual analysis in Excel. Experience in Managed Care preferred. Strong knowledge and demonstrative proficiency utilizing Microsoft Applications (Word, Excel, Access & PowerPoint). Strong understanding of accounting and financial principles and methodologies and attention to detail. Experience with Oracle or Hyperion a plus. Principles and practices of health care industry and strategies, health care systems, and budget modeling and forecasting.

**QUALITY ASSURANCE NURSE RN/LVN – COMPLIANCE**

Possession of a bachelor’s degree at an accredited four (4) year institution preferred. Possession of a RN/LVN California License. Three (3) or more years of demonstrated experience in an office environment, at a professional level, preferably in a Compliance function. Two (2) years experience in a managed care environment. Demonstrated proficiency in Microsoft Office products (Word, Excel, PowerPoint, Outlook, etc.). Excellent interpersonal and communication skills, strong organization skills, ability to establish and maintain effective working relationships both within and outside of the organization. A wide degree of creativity and latitude is expected.
Inland Empire Health Plan (IEHP) is one of the largest not-for-profit health plans in California. We serve over 1,000,000 members in Riverside and San Bernardino counties in Medi-Cal, Cal MediConnect Plan, Healthy Kids and a Medicare Special Needs Plan. Our success is attributable to our Team who share the IEHP mission to organize the delivery of quality healthcare services to our members. Join our dedicated Team!

**REPORTING ANALYST – COMPLIANCE**

Possession of a high school diploma or equivalent. Bachelor’s degree preferred. Five (5) years experience required in an office environment.

The Reporting Analyst will be responsible for providing support to the Compliance Department by developing, tracking, manipulating and monitoring reporting activities including working with the appropriate departments for regulatory reporting. Strong organizational skills and attention to detail. Proficient knowledge of Microsoft Access, Word and Excel required. Project Management experience preferred.

**NURSING INFORMATICS MANAGER**

Master’s Degree or PhD in Nursing or related clinical field, with experience in statistics and an emphasis on quantitative analysis required. Health informatics certificate preferred. 2+ years of clinical data analysis experience in the healthcare industry or medical research area.

This position reports to the Director of Medical Operations, knowledge of healthcare data (preferably managed care / health plan data) required, including but not limited to membership, eligibility, claims, encounters, pharmacy, provider, and financial data. Knowledge of CMS Star Rating methodology, HEDIS measures, and HCC risk adjustment methodology preferred. Advanced skills in Microsoft Office, SQL, and Access required. Strong analytical and critical thinking skills required. Excellent technical, interpersonal, written and oral communication skills required. Experience with data mining tools preferred.

**RISK ADJUSTMENT INFORMATICS MANAGER**

Bachelor’s degree in a health-related field required, Master’s preferred. Will accept five (5) years related work experience in lieu of education requirement. AHIMA or AAPC Certified Coder preferred. Possession of a valid California Drivers license and valid auto insurance. Four (4) or more years experience in Medicare Managed Care Plan Reporting, Medicare (RAPS/HCC Informatics at a Health Plan. Strong data analysis experience, specifically in the areas of risk adjustment. AHIMA or AAPC Certified Coder with experience in managed care, program/project management, data analysis and interpretation. Working knowledge of Medicare RAPS/HCC programs and CMS HCC coding requirements for Medicare Advantage and Part D plans. Excellent written and verbal communication and interpersonal skills, ability to establish and maintain effective working relationships with others, strong critical thinking skills required, ability to demonstrate sound analytical reasoning.

**HCC CODING SPECIALIST**

AHIMA or AAPC Certified Coder (CPC license). RN or LVN issued by the State of California required. Two (2) years experience in HCC Coding in an HMO setting is preferred. Must have strong chart audit experience in HCC Coding.

Experience in managed care, program/project management, data analysis and interpretation. Working knowledge of Center for Medicare & Medicaid Services (CMS) HCC coding requirements, ICD-9 and CPT guidelines are required. Knowledge in HCC-Risk Adjustment process and health insurance concepts as they relate to Medicare Advantage and Part D plans is required. ICD-10 coding certification preferred. Ability to take general direction and manage complex projects within deadlines. Excellent written, oral, and presentation skills. Proficiency in Microsoft Word, Excel, and other computer applications. Valid State of California license and insurance.

**PHARMACY PDE MANAGER**

Bachelor’s degree in accounting, finance or equivalent is preferred. Minimum one (1) - three (3) years experience in Medicare Part D and analyzing pharmacy data. CMS Financial reconciliation experience is preferred. PDE experience is required.

Proficient with Microsoft Office Products with the emphasis on MS Excel, SQL, and MS Access. Experience in MARx, pharmacy claims systems and accounting general ledgers is a plus. Ability to interpret detailed data and develop accurate, meaningful and reliable reports for management while meeting ongoing deadlines. Excellent written, organizational, data entry and interpersonal skills is required. Able to handle multiple demanding tasks. Ability to work and make independent decisions, maintains confidentiality, be an effective communicator and work with other team members. Capable of working with minimal supervision. Ideal candidates must have strong problem solving abilities.

**MEDICARE CLAIMS PROCESSOR**

Possession of a High School Diploma or equivalent. Three (3) years experience in adjudicating medical claims; professional and institutional preferably in an HMO or Managed Care setting; Medicare/Med-Cal experience preferred.

Microcomputer skills, proficiency in Windows applications preferred. ICD-9 and CPT coding and general practices of claims professing. Professional demeanor, excellent communication and interpersonal skills, strong organizational skills required.


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