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# HEALTHCARE FINANCE NEWS

THE BUSINESS NEWSPAPER FOR HEALTHCARE FINANCIAL MANAGERS

# Only the smartest will survive.

At TransUnion Healthcare, we believe this is true of all of us in the healthcare industry—and hospitals most of all. As hospitals struggle for survival, it's not enough to be smart. These days you need to be *smarter*.

*Which begs the question:*

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cover to find out more

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# IPAB: Why the U.S. needs it

*U.S. healthcare spending has grown dangerously out of control. Or has it?*

**A**CCORDING TO A RECENT analysis by McKinsey and Company, total spending on U.S. healthcare in 2009 was \$2.5 trillion, equivalent to 17.6 percent of the U.S. gross domestic product. The U.S. spends more on healthcare, per capita and as a share of GDP, than any other nation in the world.

At the same time, however, the U.S. has experienced eight consecutive years of declines in healthcare spending growth. The McKinsey research reveals that year-on-year healthcare spending growth in the U.S. fell from 9.5 percent in 2002 to 4 percent in 2009. In 2010, spending growth declined further to 3.9 percent.

So healthcare spending continues to grow in the U.S., but is that level of growth not a problem for the U.S. economy, or less of a problem than healthcare reformers claim?

The answer to both questions is no.

The McKinsey research adds a very important caveat to the revelation that U.S. healthcare spending growth has experienced a slowdown. McKinsey notes that healthcare spending continues to "exceed expected levels by roughly the same margin that it did in 2006."

This is a critical insight, for the organization has created a measure it terms ESAW, or Estimated Spending According to Wealth. ESAW models how much a nation would be expected to spend on healthcare based on per capita GDP. According to data compiled by the Organization for Economic Cooperation and Development, the United States spent 2.5

times more per capita on healthcare in 2009 than other developed nations. The McKinsey research reveals that 23 percent of total U.S. spending was above expected levels in 2009, compared to 22 percent of spending in 2006.

As the McKinsey report points out, since the U.S. economy grew more slowly during the same period at which healthcare spending growth grew slower, "the gap between the level of spending and what would be expected based on spending patterns in other countries and differences in per capita GDP actually grew."

Indeed, by these lights, U.S. spending on healthcare in 2009 exceeded expected levels by \$572 billion.

An assessment of this research brings me to the obligatory policy prescription: why the United States needs the Independent Payment Advisory Board (IPAB) mandated by the Affordable Care Act.

The IPAB has become a proverbial political football in the past year, but its intention is to check rising Medicare spending if per-beneficiary growth in that spending exceeds target growth rates.

Congress, whether controlled by Democrats or Republicans, has shown itself incapable of stemming the growth of Medicare spending—hence the need for an independent panel such as IPAB. Beginning in 2013, the 15-member board must recommend specific steps annually to curb the growth in Medicare spending, but *only* if the projected annual Medicare growth rate exceeds the projected annual target determined by the chief actuary of the Centers for Medicare & Medicaid Services.

Unlike some of the more overheated charges by opponents of IPAB, the board will not have the power to "ration" care. In fact, IPAB cannot propose any recommendation that would

ration care or raise revenues. It cannot offer proposals that increase Medicare beneficiary premiums or cost sharing, restrict Medicare benefits, or alter rules for Medicare eligibility.

The Medicare Payment Advisory Commission (MedPAC) currently makes recommendations to Congress about Medicare payment policies, but the proposals are ignored consistently by legislators, who are often beholden to those whose financial interests would be harmed by reductions in healthcare spending.

But given the data highlighted by the McKinsey research, it's critical that a federal panel overseeing Medicare have more power to reign in spending than the relatively toothless MedPAC.

Would that a board like IPAB were not necessary. Unfortunately, a lack of political will has made it essential. ■



**RICHARD PIZZI**

## CORRECTIONS

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## LETTERS

**Healthcare Finance News** welcomes letters on articles and issues of interest to the industry. Please limit your letters to 250 words and include your name, job title and organization, if applicable, as well as your hometown and state. The editorial staff reserves the right to edit letters for clarity and brevity.

# The best prescription for healthcare lending

**T**RADITIONAL BANKS HAVE been lukewarm when it comes to deploying capital in the healthcare industry—a sector known for its regulatory complexities and reimbursement risk even during the best of times.

It should come then as no surprise that the period during the recent U.S. financial crisis was particularly difficult. Credit tightened significantly, leaving small and mid-sized healthcare providers and vendors scrambling to finance their growth strategies. The healthcare reforms that followed only served to heighten uncertainty, exacerbating the issue.

Challenging conditions aside, lending did not dry up completely. In fact, compared to other sectors at the time, total healthcare merger and acquisition activity fared relatively well. What the overall numbers obscure, however, is the amount of extra effort that was required to secure much-needed financing. With fewer lenders specializing in the industry, healthcare vendors and providers were forced to approach multiple lenders to successfully complete their deals.

**A VARIETY OF FINANCING REMEDIES**  
As credit conditions may be poised

to tighten again, the BDC (Business Development Company) business model appears to offer an important advantage over traditional lenders: a wider range of financing solutions.

Lending BDCs enjoy diverse sources of liquidity, ranging from secured/term debt and SBIC financing to securitization financing and long-term credit facilities. Since each pocket carries its own cost and covenants, well-established BDCs are able to offer a superior product suite that runs from low multiple, senior secured debt all the way to straight unitranche or mezzanine finance.

Traditional banks, on the other hand, are prohibited from offering one-stop financing or unsecured lending. For companies looking for a streamlined and efficient way to access a comprehensive array of financing alternatives, working with a BDC can remove some of the headache—and execution risk—that stems from dealing with multiple lending partners.

**BDCS MAY BE THE CURE**  
Structural dynamics and demographic trends tend to drive a continuous need for financing

in the healthcare industry, whether to underwrite mergers and acquisitions or fund capital expenditures. Yet, unique risks—from strict regulation and a heavy emphasis on government payment sources to the idiosyncrasies of healthcare receivables—create a steep

learning curve.

That is why healthcare companies require stable lenders with a strong, ongoing commitment to the sector. They need financing partners who possess the insight and wherewithal to lend—even during difficult market environments. With its sole mission to facilitate private financing to small and mid-sized businesses, the BDC is better positioned to meet this mark.

Established by Congress to foster small business growth, BDCs are obligated to offer to provide managerial assistance. Because of this, their industry knowledge tends to run more than surface-deep—a stance that underscores their position as a more suitable lending partner. In fact, it is not uncommon for top-tier BDC professionals with a healthcare specialization to speak at industry conferences, attend Congressional testimony and keep highly



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# Physician confidence = successful payer negotiations

**S**UCCESSFUL PAYER CONTRACTING is one of the many important duties for safeguarding the long-term financial stability of a hospital-based physician practice. Whether contracts are self-renewing year-to-year or contain end dates that force physicians and payers to renegotiate agreements regularly, the payer dictates the terms unless the practice is prepared for negotiations.

There are many factors to a successful negotiation – from the gathering and familiarity with practice data, thoroughly understanding existing payer agreements, to sheer persistence.

## USE EXPERIENCE WISELY

While many physicians may feel lost when it comes to contract negotiations, many have more experience than they know. In fact, physicians negotiate on a regular basis in their daily lives, as do most people. The confidence to negotiate is again, like most forms of confidence, rooted in preparation.

**“The confidence to negotiate is again, like most forms of confidence, rooted in preparation.”**

– David A. Myrice

When a physician talks to a patient or another physician about a medical condition, they approach it with confidence because they have been prepared for this sort of scenario. If negotiations are approached in the same manner, success will be more likely too.

Physicians are highly educated and capable of connecting complex issues to come up with a diagnosis. Approaching a contract negotiation in the same fashion will improve the odds of success, but more importantly, being prepared instills confidence.

## SEEK LEVERAGE

When approaching a negotiation, understanding what your other contracts pay, what the volumes are by payer and what the payer relationship with your hospital is, are important. If a payer is not in line with other payer rates in your market, this needs to be pointed out. Also, working with the hospital and understanding its rela-



**DAVID A. MYRICE**

tionship with the payer is vital. With hospital support, your chances for a good outcome are greatly enhanced.

It all boils down to having the necessary facts about your practice, existing contracts, the payer's position in your market and importance to your hospital to convince payers that the rate suggested is fair and equitable.

## MAKE PREPARATIONS

First and foremost, knowing and understanding the complex language within the contract is critical. Second, having practice data to compare rates with is an absolute must, including the ability to measure and communicate practice volumes and the ability to use other contracts as leverage, as previously discussed.

It is also important to understand that the rate paid, while clearly the most important part of any contract, is not the only important part of a contract. How fast payments are required from the payer, the term of the agreement, how denials are handled, among other issues, need to be part of any discussion.

It is important to mentally prepare. Every physician should already know at what point they will walk away from negotiations. While this should always be considered the last resort, it can't be removed from the table. At the end of the day, this is truly the only real negotiating leverage a practice has. However, using this option without hospital involvement can be perilous. The payer knows this too, so this should never be used as a threat, but only as a last resort.

## DON'T SETTLE FOR LESS

Payer negotiations are a process, and the real power lies with physician knowledge and involvement. It is important for physicians to keep up their guard and not get confused by payer tactics or play on numbers. Preparation and a thorough knowledge of existing contracts can enhance a physician's value to the practice, increase confidence in negotiations, and add to the ability to work with payers on issues.

While utilizing the skills and expertise of non-physician professionals is advisable and adds great value, the need for the personal involvement of the physician cannot be overstated. If the payer knows that the physicians themselves are knowledgeable and come prepared to the negotiations, it does add weight to the practices, chances for a better outcome. Remember, confidence comes from knowledge and knowledge comes from preparation. ■

David A. Myrice is a senior finance manager with CBIZ – MMP.

## 2012 NEWSMAKER



**Mary Ann Freas**

*Chief Financial Officer*

**SOUTHWEST GENERAL HEALTH CENTER  
MIDDLEBURG HEIGHTS, OHIO**

**Can you talk about how your job has evolved since you started as CFO at Southwest General?**

When I walked into my position in December 2008, the economy was in turmoil. We were entering very uncertain times, with healthcare reform, the advent of the RACs. The key for me was to make certain our hospital remained a viable resource for the community. We started by mak-

ing certain all the basics were in place. About a year before I arrived, Southwest General went through a fairly large cost reduction initiative. We paid attention to our operating expenses, our cost per case, our revenue realization. My role is to set a course for the business office, to set expectations, but the people who push it through are my colleagues who work in patient accounting, registration and payer contracting.

**What was the biggest impact of the recession on Southwest General?**

The first thing that we needed to address was the value of the investment portfolio. We had to reevaluate our asset allocations to make sure we were not exposed to too much risk. In addition to that, there was the threat of an increase in uncompensated care, as a lot of people in our community lost their jobs. After developing our 2009 operating budget, we created a contingency budget to identify all those things that *could* happen but we didn't plan for, such as lower patient volumes, higher bad debt and charity care expenses. We had to be prepared for these occurrences. The contingency plan involved about \$4 to \$5 million in cost reduction that we did enact.

**You mentioned RAC audits. Was preparing for RAC a complex process?**

It was primarily a matter of providing vision and direction. It was not a lengthy process. I knew what we needed to do. We started with the assessment. We identified the areas where we needed to improve. It was also aided because we didn't begin to receive letters from the RACs until the end of 2009, beginning of 2010.

**Were your labor costs impacted by the recession?**

In 2006-07, Southwest had been through a large cost restructuring. At the time, the hospital had downsized its labor force considerably. In 2009, we delayed our merit increases, which allowed us to minimize layoffs. We now have a more sustainable approach to our labor management. We have the long-term concern about Medicare payment reductions, so labor costs are always an ongoing challenge. We have a benchmarking process and productivity system in place. We have implemented a process improvement program.

**Did you cut back on capital projects over the past few years?**

In December 2008, the big capital project at this hospital was a \$25 million information technology improvement project. We've just completed the third year of that project. That project helped us prepare for meaningful use, and to help us manage our costs through technology. Our board has just approved a \$62 million expansion of our emergency department and critical care unit. We're working on the financing of that project and expecting to break ground in the spring. Southwest has been pretty conservative in its capital projects in the last few years.

**What will be the biggest impact of healthcare reform on Southwest General?**

Medicare is 50 percent of our revenues, so what happens there will have the biggest impact on us. We think we understand the impact of value-based purchasing and readmission penalties. The fate of the state exchanges will have an impact.

**What will your major focus be in 2012?**

Leading our organization to focus on reducing cost per case. That's the key. We have to plan that our reimbursement per case will go down. The additional emphasis will be the same old basics: manage the cash flow, manage the projects and make sure we make the right investment decisions in terms of our capital.

## BROWNE

CONTINUED FROM PAGE 10  
regarded industry consultancies on permanent retainer.

## CONSIDER A SPECIALIST

BDCs' distinctive model confers certain benefits, such as an authentic underwriting specialization in industry verticals like healthcare. With a deeply honed, industry-specific underwriting expertise, BDCs were better equipped to differentiate

between good credits and riskier ones – a far cry from the conservative, one-size-fits-all approach that many traditional lenders take. For instance, it is not uncommon for a bank to broadly categorize healthcare lending as 'real estate lending' as opposed to business lending. From this standpoint, it is not hard to see why the sector suffered during the last downturn.

It appears that BDCs' strong focus on underwriting discipline

has borne fruit. For example, over the past five years, the average cumulative loss rate for BDCs was only 111 basis points (bps) per year – a figure that stands considerably below the 155 bps per year that banks have averaged.

Looking ahead, if the U.S. economy enters another soft patch and credit conditions deteriorate, a select group of BDCs seem better positioned to continue to support this sector. In addition to their flexible financing solutions, many BDCs

have used the intervening years since 2008-2009 to shore up their balance sheets. These niche players can also draw upon hard-earned underwriting expertise to analyze underlying company fundamentals – increasing the likelihood of successful deal completion.

## GET A REFERRAL

When considering a BDC specialist, it should be emphasized that they are not all the same. Some BDCs experienced dif-

ficulties during the recent economic downturn when reliance on short-term revolving bank facilities left them stranded. When looking at a prospective BDC, companies would be wise to choose one with modest balance sheet leverage, diverse sources of funding, a meaningful hold size and significant ongoing capital availability. ■

Greg Browne is managing director at Fifth Street Finance.