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Patient Safety: Demand for Change in Anatomic Pathology

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Today, more than ever, health care providers are facing increased demands to control costs and address patient safety issues. One attractive area for all medical specialties is to reduce errors. Published data indicate that laboratory services, while consuming about 10% of the health care budget, drive 60-70% of health care decisions.¹ In no area is this more apparent than Anatomic Pathology, where patients experience surgery, radiation, chemotherapeutic and other treatments – all critically dependent on the accuracy of pathologic diagnosis.

An April 2009 article in the American Journal of Clinical Pathology by Zarbo et al at Henry Ford Hos-

pital in Detroit² showed a dramatic reduction in anatomic pathology errors (62% reduction in misidentified cases and 95% reduction in slide misidentification) after implementing a bar code labeling system throughout their work process. Our own experience is much the same. Applying grocery store technology is not as glamorous as delivering a chemotherapeutic agent directly to its target by monoclonal antibody, but it has substantially improved patient care.

In 2007, as we planned the opening of our new centralized anatomic pathology laboratory, we identified two common sources of errors:

- Transcription errors associated with typing or hand writing

numbers or patient identifying information from one media to another.

- Paperwork and specimen/slide mismatches

With an opportunity to create a laboratory from scratch, we committed ourselves to finding ways to eliminate or substantially reduce hand labeling or transfer of case numbers using careful and complete use of bar codes and to digitize paper records and attach them at first point of contact to
Please see>Safety, P4

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LETTERS TO THE EDITOR

If you have questions or suggestions regarding the News and its contents, please reply to dpeel@wahcnews.com.

Letter from the Publisher and Editor



Dear Reader,

We recently began accepting reservations for articles to be published in 2010 editions of the Washington Healthcare News. Why would we begin doing this so early? After all, it's still the summer of 2009!

The main reason for accepting article reservations so early is it allows us to do a better job of planning and organizing our 2010 operations. The number and type of articles we publish drive everything from negotiations with our third-party printer to our staffing needs.

On July 31st, our first day of accepting reservations, we received requests to publish 45 articles from 18 separate organizations. We will publish between 90 and 110 articles in 2010 so this was significant. Most of our articles are written by consultants, financial professionals or attorneys and most writing in 2010 have written for us before.

To see who will be writing our 2010 articles visit our web site at www.wahcnews.com. Click on the "Writers" tab at the top right of the page. We will update this page as additional articles are reserved.

David Peel, Publisher and Editor



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< Safety, from P1

each case record.

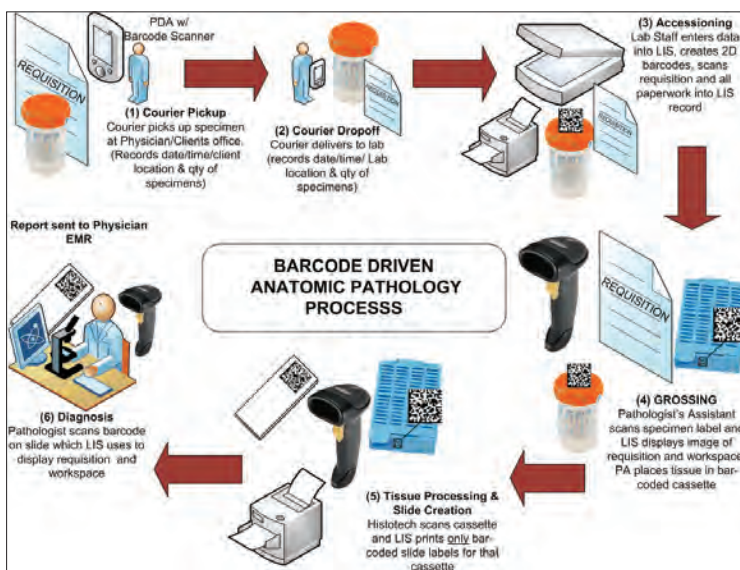
We use bar codes to track specimens from the time they are picked up by our couriers and to register their arrival at the local laboratory. The FedEx style of tracking assures that we know what we pick up from each client, and where specimens are throughout our system. Bar codes are placed on the client's counter top and on the CellNetix provided requisitions. When received in the laboratory, staff, handling one specimen at a time, print and apply 2D (two dimensional) bar code labels, and all accompanying documents are digitally scanned into the specimen LIS record. No further manual entry of accession codes is required and the paper documentation is available to all staff working on the patient specimens.

Pathologists receiving the slide trays no longer have stacks of paper work accompanying the slides. They scan a slide from the case and the LIS displays the image of the requisition (and any other accompanying paper work) on one half of the work screen with the pathologist report template on the other half. It speeds the process and reduces the opportunity for error.

Patients are not the only beneficiaries of quality improvement. CellNetix has seen its malpractice rates drop 5-10% because our insurer recognizes the improved quality. David B. Troxel M.D., Medical Director of The Doctors Company, reports that from 1995 through 2003,

of 722 reviewed pathology claims across all its insured clients, 70% showed repetitive patterns suggestive of systematic errors. Of claims, 65% centered on certain high-risk diagnostic challenges in breast, melanoma, lymphoma and system errors.³ Active efforts to identify and eliminate systematic errors and provide sub-specialty support in these areas make a difference.

Combining the anatomic pathology and cytology work volumes from multiple hospitals and communities has allowed us to perform more esoteric testing in a centralized laboratory where we control the turnaround time, methods, and qualifications of those performing the



work. A large immunohistochemistry (IHC) menu, flow cytometry, molecular diagnostics and fluorescent in situ hybridization (FISH) capability reduces turnaround time and provides faster diagnoses to our clients, shorter hospital stays and more rapid treatments. Hospital clients have realized reduced costs for technical services and improved satisfaction of their surgeons and oncologists. Shorter length of stays result in cost savings for hospitals.

Reviewing practices across multiple institutions has allowed us to identify and adopt best practices. Standardizing our procedures reduces errors and makes us more efficient. Regular review of utilization reduces cost and improves the speed of reporting final diagnoses to our physician colleagues.

Primary responsibility for recognition, funding and early adoption of innovative patient care improvements continues to rest with physicians and administrators responsible for the departments and services they provide. The tools and resources are available to dramatically reduce error in anatomic pathology while staying abreast of rapidly changing diagnostic approaches in the medical world. Professional leadership demands early, voluntary adoption of new tools to improve patient care without waiting for regulatory demands.

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Rush Commercial Teams to Build Tacoma's Carol Milgard Breast Center

By Roberta Greenwood

*Contributing Writer
Washington Healthcare News*

Delivering on their company tradition which emphasizes extensive building experience, industry partnerships, and valuable ownership insights, Rush Commercial celebrated the opening of the Carol Milgard Breast Center (CMBC) in Tacoma, Washington on February 23, 2009.

CMBC offers screening and diagnostic services, including digital mammography, breast ultrasound, breast magnetic resonance imaging (MRI), breast biopsy, and bone density services. Support programs are hosted for patients, survivors, and their families as well

as educational programs for both physicians and members of the community. Named in honor of a long-time Tacoma resident and 30-year breast cancer survivor, the CMBC was possible in large part due to the generous donation of the Gary E. Milgard Family Foundation.

Located at 4525 South 19th Street, CMBC is conveniently located near Highway 16, offering easy commuter access and ample parking space. The opening of the not-for-profit facility culminates a

community collaboration of more than three years and brings together the resources and skills of the Franciscan Health System, Multi-care Health System and TRA Medical Imaging. Director of Facilities for Franciscan Health System, Wade Moberg, praised the project, calling it world class.

"We're fortunate to have partnered with Rush in developing several community clinic facilities as well as our recently completed world class, state-of-the-art Breast Center," Moberg said. "Rush continues to deliver the best value for our dollar without compromising on our vision as is evident with our latest and most innovative community clinic to date."

of its prime location," says founder and owner Gordon Rush. "We had a comprehensive understanding of how to select the best materials and methods of constructing a space that would fiscally deliver the look and feel they wanted."

That "look and feel" includes a comfortable, spa-like interior, which offers each patient the highest quality breast imaging available and a calm, peaceful atmosphere. "The primary design intent was to remove the sterile, clinical feel to the facility and replace it with a warm, welcoming environment," explains Rush Vice President of Business Development, Jarrod Fenberg. "This facility provides total breast health imaging care,

delivered in a resort-like setting."

As patients enter CMBC, they interact with staff at a concierge desk; from that initial contact, patients are directed to various imaging services. Warm colors are utilized throughout the

center with stone, wood and glass adding to the overall sense of comfort in the facility. Direct and indirect light enhance the center's open feeling, with curved walls and radius ceilings adding to the texture of the interior. Patients enter large, private dressing rooms, where they



Carol Milgard Breast Center in Tacoma, WA

As partners in this venture, Rush Commercial managed the project from the onset with the goal to deliver an aesthetically pleasing facility coupled with state-of-the-art technologies – on time and within budget. "We've always known this building was special because

change into robes and proceed to exam rooms that feature warm woods and wood-grained flooring. “We worked with our design teams to provide a unique, comprehensive facility that has a touch of femininity to it while providing leading-edge technologies,” says Fenberg.

Doing business for more than twenty-two years, locally owned Rush Commercial provides contracting services for every step required to complete a project, CMBC is an outstanding example of that commitment to excellence, according to Dale Anderson, Principal Architect, at BCRA. “It’s a pleasure to partner with Rush Commercial in bringing our collective expertise to the table for CMBC. This facility is a wonderful addition to the South Puget Sound Community,” he says. “The collaborative efforts of the whole team are ap-

parent when you experience the harmony between aesthetics and function. Rush’s ability to turn our expressions of creativity into reality has made the Center a beautiful space.”

Beautiful, as well as focused on quality care for the patient, CMBC features the most technologically advanced equipment operated by the most highly trained medical professionals and board-certified radiologists in the region. According to Medical Director Khai Tran, MD, “This high quality diagnostic care significantly reduces the time from screening to diagnosis – enabling patients and their physicians to make treatment plans in a timelier manner. We knew that women needed a place that combined the best technology available with a holistic, restful environment.”

Adds Fenberg. “We’re proud that Rush Commercial played a role in

bringing this much needed center to the Tacoma area.”

The vision of the CMBC was to have a center that ensured patient privacy and dignity while they obtained the finest care in the region, according to Marcy Parsons, Program Director, CMBC. Adding that the Rush team showed incredible dedication to meeting the goals of the Center, she also praised Rush for bringing the project in under budget. Moberg concurs. “Rush Commercial is more than a design-build company; we consider them a valuable partner in all our projects. Whether they have competitively bid a job or negotiated work, we have always found them to be one of the most cost effective contractors we’ve worked with in the South Sound.” For more information on Rush Commercial visit www.rushcommercial.com or call 253-858-3636.



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DB Retirement Plan Management Part 3: How Do You Measure Success?

By Ward M. Harris
Managing Director
McHenry Partners



HAVE A PLAN

Retirement laws and prudent investor regulations require that plan sponsors, investment committees and advisors (all legally defined as “fiduciaries”) act with the skill, care and diligence of a “prudent expert.” Many legal and investment observers interpret this to mean that, at a minimum, the organization and supporting professionals adopt a defined and documented process, based upon an investment policy that lays out the objectives, constraints, preferences, procedures and practices that will be utilized in the fulfillment of the plan’s investment mission.

These standards apply not only to pension plans which directly impact the balance sheet and income statement of the organization (including net worth and profitability

in some years), but also defined contribution retirement plans such as 401(k), 403(b), 457 arrangements and even foundation and endowment accounts.

With the written investment policy or “recipe” in place, plan fiduciaries can then implement the plan subject to the business issues that the investment marketplace and vendor service issues may impose.

BENCHMARKING: RETURN, RISK & EXPENSE

The investment committee needs to be able to prove that it did the right thing, in the right way, for the right reasons, at the right time, with the right manager, vendor or advisor. The issues that the regulators or plaintiff’s counsel will seek to discover won’t deal with results as much as your attempts to “do the right thing.”

If you start with an investment policy that says: “We want investments that produce above average returns, with below average risk, and we want to pay no more than average expenses,” then you have defined your investment selection and monitoring standards.

You can then benchmark your investment return, risk and expense results period by period, compared to various peer groups – other investment alternatives and other plan sponsors of a similar size and plan.

Benchmarking services should be delivered by an objective third party; a professional other than the

guy or gal who sold you the products that are being measured and reported upon.

Such reports typically include a narrative review of the market environment to help apply the current investment performance back to economic, political and investment forces in the marketplace.

PAY-OFF

The quarterly benchmark report is used to review and compare the plan’s investment results in the context of general and plan-specific issues. At the end of the process, the committee is able to adapt and adjust its investment plan to enhance its investment results, for the benefit of the retirement plan, its participants and the plan sponsor. Everyone wins.

To receive a sample copy of an effective plan benchmark report, call or email the author of this column. See how risk, return and expense tie together, based upon minimum standards and peer comparison.

Next Month: “Retirement Plan Management: OK, We Have a Report, Now What?”

Ward Harris is Managing Director with McHenry Partners, a regional investment consulting firm. A Seattle native with 30 years of experience in investments for corporate and not-for-profit organizations. Call him at 1-800-638-8121 or ward.harris@mchenrypayers.com.

A photograph of the Aurora Borealis (Northern Lights) in a dark night sky. A bright, curved band of green light dominates the left side, with a smaller, brighter spot of light visible further to the left. The bottom of the image shows the dark silhouette of a landscape with some structures.

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Are the Assets in Your Trust Accessible to Creditors?

By Kay B. Abramowitz
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Ater Wynne LLP*



By June Wiyrick Flores
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Ater Wynne LLP*



A question we're often asked is whether a trust provides asset protection – can my creditors reach the assets in my trust? The answer is usually yes – most estate planning trusts do not provide asset protection for the person who created the trust (the settlor). Generally, if the settlor can use the trust's assets, then the settlor's creditor can reach the trust's assets. However, a special type of trust, called an asset protection trust (APT) may protect the trust's assets even though a settlor has limited access to the trust's assets.

Fewer than 15 states have provisions for an APT. Oregon and Washington do not, but Alaska has provisions for an APT. Alaska law provides that a settlor can create a

trust that includes a provision that the beneficiary's interest may not be "voluntarily or involuntarily transferred before the distribution is paid or delivered to the beneficiary" (this is called a spendthrift provision). This provision prohibits a creditor that existed at the time and after the APT was created from using the APT's assets to pay the creditor's claim unless an exception applies. If a settlor receives a distribution from the APT, then the creditor may be able to access that distribution.

To qualify as an Alaska APT, the trust must include the following: (1) a provision that the trust is irrevocable (it cannot be amended); (2) Alaska law governs the validity, construction and administra-

tion of the trust; (3) a spendthrift provision; (4) a qualified trustee; (5) assets deposited in Alaska; and (6) the settlor must sign a solvency affidavit prior to transferring assets to the trust.

The settlor may retain the right to receive "discretionary distributions" of income or principal from the trust's assets. Discretionary distributions means that the trustee decides whether to make and the amount of the distributions that may be made to the settlor. The settlor's right to receive distributions should not be mandatory because then the creditor may force the trustee to make a distribution and access those distributions. The settlor may "use" certain trust assets – like real estate or tangible personal property and those assets would not be subject to a creditor's claim.

A "qualified trustee" is an Alaska resident individual, trust company or bank with trust powers headquartered in Alaska. The settlor may serve as an adviser to the trustee or as a non-qualified co-trustee so long as the settlor does not retain control over discretionary distributions. (The settlor cannot as co-trustee make decisions regarding distributions to the settlor). The qualified trustee must be responsible for maintaining trust records, preparing or arranging for the preparation of the fiduciary income tax returns, and part of the trust administration must

occur in Alaska.

There are exceptions to the rules which allow a creditor to reach the assets of the Alaska APT. If the transfer of the assets to the trust was fraudulent or was intended to hinder, delay or defraud a creditor, then the court will not uphold the spendthrift provision. However the creditor must have been a creditor when the APT was created and file a law suit on or before four years after the date of the transfer to the trust or one year after the creditor discovered the transfer (10 years for bankruptcy if there is fraud).

As long as the settlor creates the APT and transfers assets to the APT before any claim has been asserted, the claim is barred against those assets. A potential claim or liability is not enough. Those people who are in high risk profes-

sions or businesses may still adopt an APT that will protect them against potential risks that are not yet a specific claim.

There are several groups of people who would benefit from an APT including (1) professionals at high risk of potential liabilities or litigation; (2) couples seeking an alternative to a prenuptial agreement; (3) people wanting to protect a nest egg; and (4) people who are vulnerable to financial scams. An Alaska APT can be a very effective tool for protecting an individual's assets from future creditors. However, they are not appropriate

in every situation so care must be taken in establishing an APT.

Kay Abramowitz and June Wyrick Flores focus on wealth preservation through estate planning, estate and trust administration, entity formation and business planning. Abramowitz chairs the Wealth Preservation Group and the Family-Owned Business Group of Ater Wynne LLP and can be reached at kba@aterwynne.com or at 503-226-8437. Wyrick Flores can be reached at jwrf@aterwynne.com or at 503-226-8432.



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How Benchmarking Can Help Your Facility Achieve Financial Wellness

By Donna Herbert
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By Joe Davis-Fleming, MS
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Senior Consultant
Financial Consultants of AK & WA



Insurance Payment per Patient
Discharge Percentages, Con-
tractual Allowance/Bad Debt/
Charity Percentages, Person-
nel & Administrative Expense
Percentages (of Operating
Costs), Case Mix Index

While each of these metric categories focus on different aspects of a facility's operational and financial condition, collectively these indicators can help management establish trends over time and strategically make critical management and budgeting decisions based on the results. By using data derived from a reliable source like the Medicare cost report to formulate most of these indicators, facilities can also compare their performance with their peers and industry best practice benchmarks.

These performance "flash points" can also provide facilities with timely, needed information to detect financial distress signs and billing noncompliance. How? By specifically targeting areas of patient care and support operations that require immediate corrective action, as well as systemic improvements to effectively respond to internal and external factors that impact facility financial performance and long-term viability.

Once key problems have been identified, a corrective action plan can be developed to remedy the root causes of those factors that often lead to a distressed financial situation:

1. Define Scope of Corrective

During these turbulent times of economic uncertainty, healthcare providers must be vigilant in effectively monitoring and aggressively managing their bottom line to ensure long-term viability of their facility. Benchmarking your facility's performance using financial metrics and data analysis tools are keys to this process. It transforms Medicare cost reporting and billing compliance to proactive financial management and budget forecasting. If information derived from your reporting systems is applied appropriately, these tools also help to detect and resolve major problem areas.

Operational and financial performance indicators that should be regularly analyzed and evaluated include:

- **Profitability Ratios:** Operating Margin, Income Index, Return on Equity, Equity

Growth Rate

- **Liquidity Ratios:** Current Ratio, Days Cash on Hand, Average Net (of contractual write-offs) Days in Patient Accounts Receivable by major payer class, Average Payment Period
- **Capital Structure & Liability Ratios:** Long-Term Debt to Capitalization, Equity & Fixed Asset Financing, Cash Flow to Total Debt Ratio, Debt Service & Expense Percentages
- **Asset Efficiency Ratios:** Total/Fixed/Current Asset Turnover, Inventory Ratio, Average Age of Plant, Depreciation Rate
- **Operational & Reimbursement Ratios:** Average Revenue per Patient Day, Average Cost per Patient Discharge, Average Cost-to-Charge Ratio, Average Medicare/Medicaid/

Action Plan – Target major patient activity processing and reimbursement problem areas adversely affected by current patient care practices, including high risk patient billing and compliance categories targeted for OIG, Medicare Recovery Contractor (RAC) and Medicaid Integrity Program (MIP) Audits.

2. Collect and compile Medicare and Medicaid billing denials and payment recoupment data for current and previous fiscal cost reporting periods; perform trend analysis of results; immediately address compliance issues, correct, resubmit and/or appeal claims that have technical billing and coding errors but have supporting medical documentation – prioritize based on highest billed amounts and filing/appeal deadlines.
3. Conduct comprehensive re-

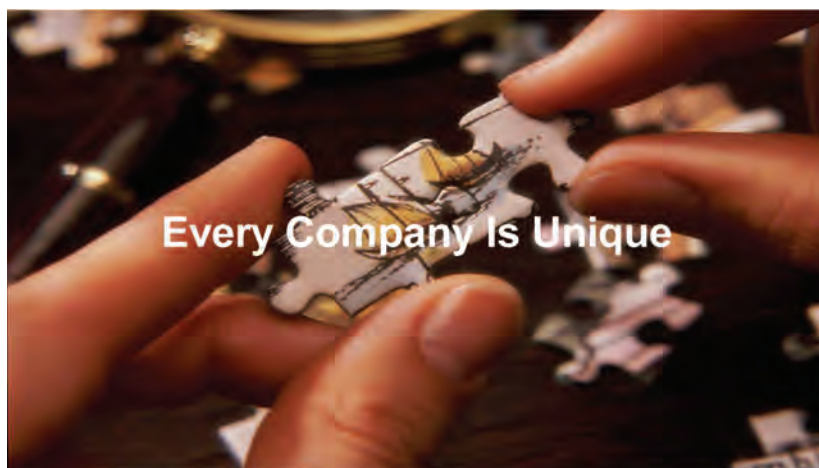
view of entire reimbursement and reporting process, from point of patient registration, service coding and charging, utilization review, medical documentation, post-discharge billing reconciliation, claim submission and follow-up, payment/denial tracking and transaction posting, patient care activity/resource utilization statistical and cost reporting, to reconciliation of revenue and expense results on the monthly and year-to-date financial statements; insure that proper system controls and processes are in place.

4. Analyze charge master coding, service pricing and related fee schedules, lost charges and unbilled items, reimbursement-to-billed charge ratios, contractual allowance adjustments, over coding/under coding occurrences and other

related billing compliance issues – It's been FCAW's experience with compliance audits that providers tend to under code their claims resulting in significant underpayments that should have been paid had those claims been coded correctly.

5. Analyze Inpatient DRG and Outpatient (including ER and clinic) APC acuity levels to insure accurate coding, billing compliance and optimal reimbursement.
6. Immediately resolve noncompliant billing issues by implementing corrected/updated charge codes, policy, procedures, and system controls to insure accurate claims submission and cost reporting.
7. Establish new monthly/quarterly/annual performance

Please see> Benchmarking, P16



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Errors & Omissions Insurance: What Managed Care Organizations Must Know

By Steve Couch

Principal
MedRisk, LLC



For the most fortunate of managed care organizations (MCOs), professional errors & omissions (E&O) liability insurance receives little attention except at annual policy renewal time. For the less fortunate - for those at the wrong end of a lawsuit - their E&O insurance policy will play a key role in minimizing the financial loss incurred as a result of a claim.

The purpose of this article is to help MCOs better understand:

1. Their exposure to professional E&O liability
2. How to minimize exposure to E&O claims
3. Simple insurance buying tips

The Managed Care Liability Exposure

Traditional areas of managed care risk include:

- **Medical negligence:** If a managed care organization (MCO) employs medical providers, the organization can be held liable for injury arising out of direct medical care.
- **Peer review:** An employed physician is terminated from the plan's panel without the organization following its own peer review procedures.
- **Credentialing or provider selection:** A subscriber is injured by a panel physician with a documented history of incompetence.
- **Antitrust:** A provider owned health plan controls a significant portion of the services available in a geographic area, then charges competing plans unreasonable fees for those services.
- **Vicarious liability:** If a patient/subscriber reasonably believes that a negligent provider is employed by or is acting on behalf of an MCO, then the plan may be held liable for the negligent actions of that provider.
- **Utilization review:** A physician recommends a certain course of treatment and the plan wrongly denies the recommendation, resulting in complications or injury to the subscriber.
- **Conflict of interest:** For economic reasons, health plan refuses to authorize a reasonable,

but costly course of treatment.

Recent Developments – Class Actions

In addition to the traditional risks listed above, class action suits are also on the rise. In a recent newsletter, Kristin McMahon, Esq. of IronHealth, a leading underwriter of managed care E&O, cites the ongoing class action relating to Usual and Customary Rates (UCR) for out of area benefits. She states, "the extraordinary amounts paid by health insurers,... the sizable plaintiff attorney fee awards and the Attorney General's adverse findings ... will undoubtedly embolden the plaintiff's bar in their pursuit of other UCR class action defendants."

http://www.ironshore.com/onpoint_ironhealth/onPoint_vol1_iss3.pdf

In a 2006 study, another leading underwriter, OneBeacon Professional Partners also suggests there is a trend away from bodily injury related claims toward business practices related claims. This shift has resulted in a dramatic rise in defense costs due to the complexity of these cases.

http://www.onebeaconpro.com/insights/insights_vol7.pdf

Minimizing Exposure to E&O Claims

There is no sure method of avoiding E&O claims, but Alice Johanson of IronHealth offers a few helpful hints.

Please see> Insurance, P16

A trusted guide in changing times.

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<Benchmarking, from P13

- benchmark targets and goals throughout the entire reimbursement and financial reporting process to track improvement measures taken for enhancing revenue capture, reimbursement-to-billed charge ratios, and operating margins.
8. Track reimbursement performance separately for all major payer categories (Medicare, Medicaid, Commercial Insurance, etc.), addressing deficiencies and problems specific to each payer class.
 9. Implement monthly training and updates for all staff involved in the reimbursement and financial reporting process, including billing compli-

ance requirements and performance monitoring.

10. Regularly follow-up, evaluate and report progress made in addressing operational, financial and billing compliance issues to management staff and board members.

For more information on Financial Wellness indicators, billing compliance and RAC audits, go to www.FCAWreimbursement.com.

Donna Herbert is the founder of *Financial Consultants of Alaska & Washington (FCAW)*. Since 1979, she has provided advice and counsel to health care providers in both Alaska and Washington concerning all aspects of budget, finance, and preparation of third-

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<Insurance, from P14

- MCOs should be as transparent as possible in their dealings with both members and providers. Both should know what to expect from the organization and there should be as little ambiguity in contracts as possible.
- MCOs should have up-to-date, well communicated policies and procedures and be as consistent as possible in carrying these out. Exceptions can create litigation issues down the road.
- Strive to build positive and pro-active relationships with the regulatory agencies.

Tips on Buying Insurance

A good insurance broker will direct you to the strongest underwriting companies and guide you through the minutiae of renewal applications and forms, but there are some overriding principles that

can help make your organization a more attractive applicant.

It is important to shop for competitive insurance bids at reasonable intervals. Ms. Johansson recommends, "It is appropriate to survey the market every 2-3 years ... to assure that coverage is as up-to-date as possible and is at a market competitive price. However, marketing every year can lead underwriters to not take the opportunity seriously."

John Riordan of OneBeacon Professional Partners makes another suggestion. "Probably the biggest missed opportunity is not sharing enough information. Be forward and generous with any information in order to receive the most appropriate risk management plan, coverage and pricing."

Summary

As with any business relationship, a key to a successful insurance program is good communication.

When there are material changes to your organization or operations, let your broker know. There may be coverage enhancements available to cover a new service or entity.

If incidents arise that could possibly develop into a claim or lawsuit, speak up! Your underwriter may appoint an attorney at no additional cost to help you resolve a challenging situation. Your managed care professional E&O insurer has the same goals as you – to manage your exposure and to resolve potential claims as quickly and efficiently as possible.

Steve Couch is a Principal with *MedRisk, LLC*. The firm specializes in healthcare related insurance risk such as reinsurance, stop-loss, errors & omissions, and directors and officers. Steve can be reached by phone at 503-657-7475 or by email at scouch@medriskllc.com.



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Recapitalization in the Healthcare Industry: We've Only Just Begun

By Wiley P. Kitchell
Managing Director
Moss Adams Capital LLC



The extraordinary impact of the ongoing national economic crisis has profoundly affected most sectors of the healthcare industry. Today one of the major issues confronting mid-size hospitals, and other investor-owned or not-for-profit facilities, is the ability to identify sources of reasonably priced, and structured, debt and equity capital. This financial constraint includes equity and debt for new capital projects or to help strengthen current balance sheets; debt to refinance and extend the maturity of bonds or other outstanding senior debt; and even the level of capital needed to support the continuation of operating lines at their current levels.

As the economic landscape has shifted dramatically, it is increasingly important for senior healthcare professionals to understand as many of the available financing

options as possible. In many cases, the choice and availability of financing options is now a leading factor in a healthcare company's long-term strategic planning process.

The Financing Landscape has Shifted

Prior to the middle of 2007, capital was readily abundant and healthcare facilities of all types were characterized by large investments in buildings and related medical equipment. With ready access to cheap capital, the operators of healthcare facilities were able to easily separate their strategic planning and strategic decisions, from the relatively simple task of raising capital.

Limited Access to Capital Threatens Quality of Care

During the past eighteen months, many healthcare facilities encountered tightening credit and restricted access to capital. Over the short term, most companies were able to survive by tightening their spending, cutting back on capital investments and using up their reserves. Today the recession is lowering patient counts and causing people to defer their care. Eventually quality of care will decline in those facilities that are not able to secure additional capital.

Tough Conditions will Persist

In March, Moody's Investors Service predicted that investor-owned hospitals will continue to deteriorate financially throughout 2009.

Moody's cites problems with the economy, lower patient volumes and growing bad debt costs. And in July, Moody's lowered credit ratings for not-for-profit hospitals and health systems for the third consecutive quarter. Factors that contributed to the downgrades include weak operations, dwindling cash reserves and looming maturities of debt.

Most not-for-profit hospitals and facilities rely upon variable-rate bonds that depend upon local banks for underlying guarantees. Now weakened banks either can't maintain credit ratings, or won't renew their letters-of-credit. Without the credit support, the healthcare facilities are threatened by rising interest rates.

Know the Alternatives

When facing the decision of refinancing or recapitalizing, it is critical to identify all available alternatives and to then clearly analyze each option. In the shifting landscape, non-traditional sources of capital will emerge and, in many cases, may offer strategic advantages to the professionals who are first to embrace the new sources. Some alternatives include:

- **Government funding and support.** There will continue to be government support for debt financing, and this will be an important financing alternative. For example, the federal government is trying

Please see> Recapitalization, P20

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<Recapitalization, from P18

to make it easier for not-for-profit hospitals to refinance their tax-exempt debt by relaxing certain HUD requirements. With HUD insurance, a facility may be able to refinance debt as long-term bonds with fixed interest rates.

- **Private debt.** In addition to banks, there are numerous sources that provide both short-term and long-term debt. Looking beyond the banks and understanding the criteria and attributes of each form of debt is an important step in evaluating alternatives.
- **Private equity.** Healthcare has always been an attractive market for private equity investors. Today some private equity firms are broadening their reach into investor-owned and not-for-profit facilities and healthcare projects. In the future, private equity offers a unique ability to participate in the recapitalization of select healthcare systems.
- **Existing debt presents an M&A opportunity.** When a seller has assumable debt, and a buyer does not need to obtain new financing, there is an opportunity to approach strategic buyers. If the debt is in place and has a known interest rate, a buyer can approach the potential acquisition more aggressively, than if financing is uncertain.

Plan Ahead. Be Prepared.

There are huge debt balances supporting thousands of mid-size hospitals and health facilities in the Northwest. Refinancing and recapitalizing these organizations is a significant challenge. The

decision is strategic, and business models will adapt to the capital that is available. With such important consequences, adherence to a rigorous corporate finance process is critical to a hospital or health system's ability to access capital.

Mr. Kitchell is a Managing Director of Moss Adams Capital LLC. He has more than 20 years of investment banking experience

working with privately owned companies headquartered in the western United States. He commenced his investment banking career with Goldman Sachs, in New York.

Mr. Kitchell received a B.A. degree in Economics and Anthropology from Duke University, and an MBA in Finance from Northwestern University.

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