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Board Governance: The Fun is Just Beginning

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The start of a new decade brings a number of challenges to hospitals and their governing boards. In addition to the numerous issues now facing governing bodies, 2010 will include a greater focus on board governance, including, for starters, the possible implementation of healthcare reform, increased oversight of patient safety and quality of care, and the prevention of fraud and abuse. Hospital governing boards are up to the challenge.

Healthcare Reform

In 2009, both houses of Congress passed comprehensive healthcare reform. However, at the time this article was written, the House and Senate bills had not been reconciled. Additionally, the January election of a Republican U.S. Senator from Massachusetts, which eliminated the Senate Democrats' filibuster-proof majority, has made passage of a final bill uncertain. What is clear is that with or without federal mandated healthcare reform, the way healthcare is delivered in the United States must change, and dramatic steps will need to be taken to reduce waste and increase efficiency.

The role of hospital boards in implementing and overseeing the changes required is currently uncertain, but informed decision-making will be essential for survival. An urgent task of hospital boards will be to understand the change in Medicare and Medicaid reimbursement and how it will impact their hospitals. Additionally, board members will have to grasp the implications of complying with new fraud and abuse regulations and ensuring safe and high quality patient care. It is a given that

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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 received several comments from our readers about the hospital financial information presented in last month's edition. Over 500 Director to "C" level financial executives receive Healthcare News publications so it's important our financial reporting is accurate, timely and independently derived. However, our intent is to communicate high level information to healthcare leaders in *all vocations*, not just finance, to help increase awareness of healthcare industry financial health.

Overall, the feedback from last month's reporting was good. Some told us we should provide more footnotes to explain specific situations. Others said we should consolidate reporting at some systems to show their overall picture. There is clearly an interest in receiving this type of information and we will accommodate these suggestions as space allows.

If you didn't catch last month's edition, visit our web site at www.wahcnews.com to download this financial information. Until next month,

David Peel, Publisher and Editor

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a large part of any type of reform will be paid through reductions in Medicare payments and aggressive government fraud and abuse enforcement.

There is general consensus that mandated reform will significantly increase healthcare spending with only lip service to improving quality and changing how an inefficient healthcare system works. The cumulative effect will force hospitals and physicians to work even closer together at a time when each face financial challenges not previously experienced.

How can boards respond? For starters, board members will need to be informed and educate themselves on how new legislation will impact their hospital; it is a matter of fiduciary responsibility.

Boards will want to examine how they are organized, with specific focus on board committee structure. Many hospital boards currently have a committee structure that includes finance, audit, strategic planning, quality of care, and board education, which will all need to be engaged to help boards respond to the challenges ahead. However, boards should also consider forming new committees or expanding responsibilities of current committees to focus on direct collaboration with members of the medical staff.

The emphasis on cooperation between hospitals and physicians is an important part of any type of healthcare reform. For example, both the Senate and House bills propose a pilot program that incentivizes the creation of accountable care organizations ("ACOs"). ACOs are integrated health systems generally consisting of primary care physicians, specialists, and a hospital, which are jointly responsible for patient care. By working together and meeting quality of care and cost thresholds, ACOs will be rewarded with Medicare incentives. Policy makers hope that encouraging the proliferation of ACOs will increase quality of care while eliminating wasteful over utilization of resources. Each hospital board should review the positives and negatives of creating and developing ACOs, and how to encourage physicians to enter into such an organization with the hospital.

Quality of Care

Improving patient safety and the quality of healthcare has long been a primary goal of the government and healthcare organizations. Policy makers and governmental bodies are increasingly holding hospital boards accountable for patient safety and the quality of care in their hospitals—but it appears that many boards have not taken notice.

For example, a 2009 study by professors at the Harvard School of Public Health titled "Hospital Governance and the Quality of Care" found that fewer than half of the hospital boards in the United States rated quality of care as one of their two top priorities. Instead, the boards focused on financial issues, assuming that management and other personnel would ensure adequate care of patients. Yet the study's central finding was that hospitals with boards that take an active role in overseeing patient care have better quality of care records than hospitals whose boards have little or no influence over patient care.

In light of this study and increased regulatory and payer interest on patient safety and quality of care, boards should be briefed about incidents that cause significant patient injuries and how such incidents can be avoided in the future. It is important for hospital boards to realize that focusing on financial issues at the exclusion of patient care could be detrimental and even disastrous.

Fraud and Abuse

In 2009, the Office of Inspector General ("OIG") announced that it had recorded receivables of nearly $4.5 billion through its fraud and abuse audits and investigations. In light of this success, there is no doubt that OIG fraud and abuse enforcement efforts will escalate in 2010. In fact, President Obama's 2010 budget increases the amount of money spent on enforcement activities by 50 percent over 2009's budget.

An additional tool that the federal government will use in 2010 to curtail Medicare fraud is the expansion of the Recovery Audit Contractor ("RAC") program into Washington, Oregon, and other states. The purpose of the RAC program is to identify and recover Medicare overpayments. In the initial three-year RAC demonstration from 2005 to 2008, which was conducted in California, Florida, and New York, the program recovered almost $1 billion in Medicare overpayments. The recovery of Medicare dollars will increase in 2010 and thereafter. Hospital boards should know how their hospitals are preparing

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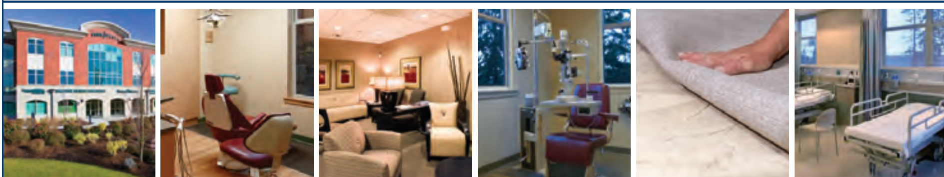

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for these audits.

Fraud and abuse enforcement is a central component of healthcare reform as one of the ways to pay for new federal programs. Among many other provisions, the proposed legislation requires that a Medicare or Medicaid overpayment be reported within 60 days after the overpayment is identified. Any known overpayment retained beyond the 60-day period could subject the providers to penalties under the False Claims Act, which includes large civil and criminal penalties.

Hospital boards should ensure that their organizations have adequate compliance programs and training so that employees understand complex fraud and abuse as well as billing rules and to whom questions can be addressed. With the increased scrutiny on Medicare payments in 2010 and government success in recovering overpayments, it is unlikely that the government will show mercy if it discovers improperly billed claims.

Conclusion

Every year brings new sets of issues to hospitals and their boards. In the wake of the difficult financial year of 2009, the new decade brings new and unprecedented challenges, which will stretch hospitals to the maximum. In order to make 2010 a successful year, boards will have to guide their hospitals on a course that balances financial responsibilities, compliance, and patient care. Indeed, those who enter a hospital boardroom in 2010 should prepare themselves for the challenge of a lifetime! But hospital boards are up to the task, and guiding a hospital to meet those challenges will provide board members with immense personal satisfaction.

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The Role of Healthcare Reform on the 2010 Financial Markets

By Luc Arsenault
Transaction Services Practice Leader
Moss Adams LLP

By Chris Pritchard
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A year ago, after the economic collapse, the only real financial transactions being completed were in pharmaceuticals, life sciences, and healthcare. Once healthcare reform became a legislative priority in Washington, D.C., however, the healthcare M&A market came to a halt.

Over the course of 2009, healthcare reform took on greater shape in the public sector and the uncertainty in the capital markets decreased. Toward the end of 2009, there was a renewal of healthcare M&A activity.

Looking ahead, we believe 2010 offers a tremendous amount of opportunity for a variety of healthcare transactions. And the next 12 months should easily make up for the stop-and-start nature of last year's market. Indeed, many of our clients who used to do two to three healthcare deals a year prior to 2009 did none last year; but they're telling us they plan to make up for the lack of 2009 transactions in 2010.

They'll be encouraged by an economy that's slowly healing as it emerges from recession. It's true that the financing environment isn't completely favorable today, but there are signs of life, and we see more and more lenders coming to the table with a renewed appetite for deals.

The positive macro transition, plus some sort of signed healthcare reform legislation, should, in the end, make the next few quarters very active ones when it comes to healthcare M&A. The only red flag—and it's an important caveat—is that healthcare reform coming out of Washington, D.C., could have a profound impact on valuations.

There are three kinds of healthcare transactions we see unfolding in 2010, and each one necessitates a different approach to due diligence.

The first involves venture-backed healthcare organizations seeking to acquire similar accretive business units because they want to create a larger healthcare organization that would be attractive to an upstream consolidator for future sale. Due diligence here demands that the acquiring healthcare organization substantiate robust EBITDA, a healthy payor mix, lucrative contracts, strong management teams, and a strategic market hold. The due-diligence process also must look for potential liabilities, such as unrecorded tax issues or regulatory issues that might place undue burden on the heath care organization. Finally, the due-diligence effort must examine structural integrity, which includes considering outdated IT systems, at-risk key employees, and deteriorating market reputation.

The second type of deal involves not-for-profit healthcare organizations seeking to acquire specific assets of target healthcare compa-

nies in order to strengthen or fill in current business needs. In this case, due diligence should consider the same items noted above, but to a lesser degree. Instead, the buyer must closely analyze the strategic nature of the target assets while minimizing possible liabilities.

The third type of deal involves healthcare organizations—either for-profit or not-for-profit—looking to divest themselves of unprofitable divisions, facing unpalatable regulatory requirements, confronted with an unworkable monopoly, or seeking a white knight to save the day with an acquisition. Due diligence in these distressed situations is usually more focused on the financial assets being acquired, the fair value of those assets, and the minimum purchase price that's acceptable.

The general rule of thumb is that the longer a due-diligence process takes, the greater the likelihood the deal will falter. That's why we recommend that healthcare buyers and sellers today focus on the push-pull dynamic, which leads to the ultimate sales price. In this dynamic, the buyer typically slows the due-diligence process down to make sure all the variables are considered and the lowest price is achieved. At the same time, the seller generally tries to speed up the process to complete the sale at the highest possible price.

These due-diligence guidelines and approaches are not hard and fast, but they do represent several potential courses of action that we believe will help buyers and sellers in the healthcare market as they complete necessary and meaningful transactions in 2010.

Mr. Arsenault is the Transaction Services Practice Leader for Moss Adams. He has more than 12 years of experience in mergers and acquisitions involving transactions ranging in size from several million to $20 billion dollars. Prior to Moss Adams, Mr. Arsenault worked at Genentech and as a life science subject matter expert in the Transaction Advisory Service group of Ernst & Young in its San Francisco, CA office. Contact Mr. Arsenault at 415-677-8287 or luc.arsenault@mossadams.com.

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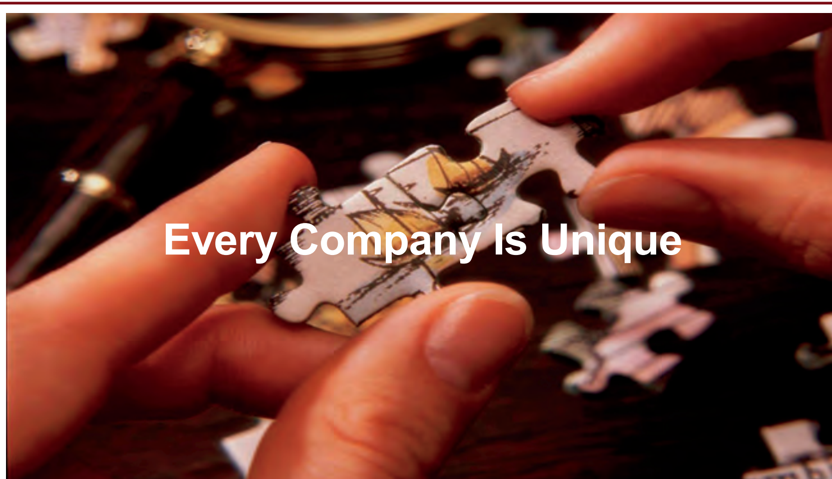

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Changes Coming for Rest and Meal Breaks?

By Tim O'Connell
Partner
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For decades, Washington employers have operated under regulations issued by the Department of Labor & Industries that establish the minimum requirements for rest and meal breaks for non-exempt employees. Generally, the regulation requires a 30-minute meal break for an employee working five or more hours and a 10-minute paid rest break for every four hours of work. Washington healthcare providers have been able to provide rest and meal breaks without any documented cases of adverse patient impact, unlike England. ("Man dies as ambulance crews take a break," *London Evening Standard*, May 1, 2007.) That may soon change.

In recent years, rest and meal breaks have generated substantial controversy – and litigation. In its 2002 *Wingert* decision, the state Supreme Court concluded that employees who did not receive required rest breaks were entitled to additional compensation even though they had been paid for the time worked. *Wingert* did not address other rest and meal break issues. Unions and employee advocates have continued to raise claims about "intermittent" breaks, the rate of pay for missed breaks, and whether employers must ensure that employees actually receive breaks. In 2010, two of the main arenas for these disputes will be in agency rule-making and before the legislature.

There is nothing new about these efforts. In the last legislative session, unions representing healthcare workers sought legislation that would have dramatically changed break requirements. Those proposals did not get very far, because of united opposition from providers as well as indications that L&I would review the regulation. L&I's involvement in this controversy was not new either. In 2007, the nurses' union argued to L&I's Employment Law Advisory Committee that the Department should no longer allow "intermittent" breaks. An intermittent break is a short period when the employee is relieved from duty and allowed to rest, for less than the full 10 minutes required by the regulation. The regulation has always allowed intermittent breaks, if the nature of the employee's work allows it and the intermittent breaks add up to at least 10 minutes for each four hours of work. Intermittent breaks have been widely used in healthcare, where employees are able to step away from patients or their duties for a few minutes at a time for needed rest or reflection. To some union leaders, despite the popularity of intermittent breaks, only scheduled "block" breaks are sufficient. Union leaders, however, were able to offer only anecdotal evidence to back up their opinions, and L&I did not revise its regulation.

That is not the end of the story, and may only be the beginning. For at least two years L&I has been informally working on potential revisions to the rest and meal break regulation. The latest version continues to permit intermittent breaks, but requires employers to establish written policies detailing how such breaks can be used. It remains to be seen what will happen in the rule-making process.

Simultaneously, unions and their allies have again turned to the legislature. The legislature is currently considering several proposals addressing rest and meal breaks. At least one bill, HB 2737, would effectively ban intermittent breaks – requiring any employer that sought to continue to use intermittent breaks to obtain a waiver from L&I. The bill would allow two

years for the Department to prepare rules for such a waiver process and for employers to obtain waivers before intermittent breaks would be banned. It is, of course, anyone's guess how the requirement for a waiver would impact a practice used today by the vast majority of employers throughout the state.

Another bill, HB 3024, is applicable only to hospitals. It would require uninterrupted meal breaks, although the effect on rest breaks is unclear. Other proposals would require consideration of staffing for rest and meal breaks in the staffing plan required by RCW 71.41.420, and would mandate coverage of intermittent breaks in the collective bargaining process.

The 2010 legislature is a short (60-day) session, so it is difficult to predict whether any of these proposals will become law. Even if they do, none resolve some of the other controversial issues surrounding rest and meal breaks, such as the appropriate rate of pay for an employee who missed a rest break but was paid for all time actually worked. Healthcare providers, like other Washington employers, will have to wait for further guidance before all the questions that arise from these seemingly simple workday requirements can be answered.

Tim O'Connell is a partner of Stoel Rives LLP. His practice includes representing healthcare providers in NLRB and PERC proceedings, labor arbitrations, equal employment and discrimination cases before administrative agencies and courts, wrongful discharge litigation, wage-and-hour counseling and litigation, and general personnel management. Contact Tim at tjoconnell@stoel.com or 206-386-7562.

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Credit Market Overview Cites Fourth Quarter Activity

Editors note: This overview of the U.S. credit markets was provided by Prime Advisors, Inc. Prime, based in Redmond, Washington, currently manages $9.6 billion in core fixed income investments. To learn more about Prime, contact Ryan Leahy at 425-202-2018 or ryan.leahy@primeadvisors.com.

Credit markets enjoyed outstanding performance in 2009. This was in strong contrast to 2008, the worst year for credit spreads in decades. Liquidity returned to the credit market, assisted by various government programs. In addition to government support, there is now a very strong technical bid that has developed in the market. The strong bid is largely driven by the vast amount of cash and cash equivalents being invested. Investors, tired of earning near zero for money markets and their equivalents, entered the market in an effort to capture part of the spread tightening from the opportunities created in 2008. The combination of government programs and technical support tightened spreads and revived the new issue market to near record levels. Corporations continue to reduce leverage and expenses to improved balance sheets and maintain profit margins. In addition, financial companies have built reserves to cover potential future loan write-downs and have paid back TARP capital to the government.

These efforts spurred corporate spreads to tighten 46 basis points in the fourth quarter. Similarly, spreads for BBB rated companies and the bank and finance sector tightened 62 basis points in the fourth quarter. Industrials tightened 38 basis points and utilities tightened 39. Over the course of 2009, the corporate index rallied an unprecedented 383 basis points. Notably, BBB's tightened 510 and financials tightened 403 basis points.

Although corporate spreads have rallied significantly, select BBB and financial names still have room to tighten further with about 220 basis points of spread over Treasuries, versus only 61 basis points for the aggregate index. Therefore, we retain a positive outlook on credit. This positioning should equate to positive returns in an economic environment that does not expand too quickly or succumb to an unanticipated contraction.

Furthermore, volatility has diminished but risks have not disappeared. For this reason we are not reaching for yield at this time but rather investing in top tier names throughout the credit rating mix. Interest rate, economic, merger and acquisition, and political risks continue to be potential economic hazards. Consequently, it is imperative that the investor remain cautious, focusing primarily on credit selection for the foreseeable future.

Option Adjusted Credit Spreads in Basis Points[1]

Index Sector	12/31/08	09/30/09	12/31/09	4Q09 Change	FY09 Change
Aggregate Index	213	82	61	-21	-152
Corporates	555	218	172	-46	-383
Industrials	500	176	138	-38	-362
Utilities	537	200	161	-39	-376
Financials	629	288	226	-62	-403
AAA	329	74	62	-12	-267
AA	373	141	110	-31	-263
A	506	198	158	-40	-348
BBB	727	279	217	-62	-510

[1]Data from Barclays Capital as of 12/31/09

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Government Budget Deficits Triggering Increased Provider Audits

By Donna Herbert
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In response to growing federal and state budget deficits (and many other reasons), the Office of Inspector General (OIG), the Centers for Medicare & Medicaid Services (CMS) and state governments have increased audit programs to identify improper payments. Improper payments include fraud, waste and abuse. CMS alone estimates it loses $24 billion annually through improper payments. Healthcare providers face the daunting task of keeping track of this "tangled web" of overlapping audit programs. This article provides an update on some of the current governmental audit programs underway.

Medicare

The Recovery Audit Contractor (RAC) program is fully operational in all U.S. regions. Some of the newer improper payment issues identified for audit include:

- **Not a New Patient.** Providers are only allowed to bill for new patient visits if the patient has not received any professional services from the physician or physician group practice within the prior 3 years.
- **NCCI Edits.** These apply to all HCPCS/CPT codes that are above the maximum units of service that a provider would typically report, same date of service, and same provider. Errors are identified when more units are billed than medically likely.
- **Excessive Units-IV Hydration.** Errors are identified when the maximum units billed are more than one per person per date of service.

To see all new high risk issues identified for examination visit: **https://racinfo.healthdatainsights.com/Public/NewIssues.aspx**

CMS established two other programs to recover improper payments. These programs are called the *Comprehensive Error Rate Testing (CERT) program* and the *Zone Program Integrity Contractors (ZPIC) audits*.

CERT program

The CERT program measures the error rate for claims submitted to Carriers. CERT uses independent contractors called CERT Documentation Contractors (CDCs) who request medical records directly from the provider associated with the claim. However, the CDC may also request medical records from providers not associated with the claim who have submitted claims for the same patient. The idea is to identify potential duplicate payments and other issues.

For more information on the CERT program visit: **www.certcdc.com/certproviderportal**

ZPIC audits

ZPICs are organizations hired indirectly (or in connection with other CMS affiliated contractors) by CMS to perform a wide range of medical review, data analysis and Medicare evidence-based policy auditing activities. While ZPIC audits are similar in many ways to other CMS audits they do differ in one very import aspect - they take into account the potential of provider fraud.

Medicaid

There are two ongoing audit programs associated with the CMS Medicaid program: the *Medicaid Integrity Program (MIP)* and the *Surveillance & Utilization Review Subsystem (SURS) program*.

MIP Program

The Deficit Reduction Act provided CMS the first-ever national state strategy to detect fraud and abuse. The MIP was developed as a joint state and federal program administered by the OIG Medicaid Fraud Division.

The MIP will use Medicaid Integrity Contractors (MIC) to perform audits and develop data mining software and other reporting tools. MICs are external entities who will perform the following functions:

1. Review provider actions
2. Audit claims
3. Identify overpayments
4. Educate providers, managed care entities, beneficiaries and others

To learn more about the MIP visit:

www.cms.hhs.gov/MedicaidIntegrityProgram

SURS program

The SURS is a component of the Medicaid Management Information Systems designed to process information on medical and healthcare services to assist Medicaid program managers in identifying possible fraud and abuse by providers and Medicaid recipients. State SURS staff perform data mining and other research for post-pay utilization review of providers and recipients in order to identify questionable patterns of service delivery and utilization.

The Audit Response Plan

Many of the CMS audit programs rely on independent contractors who are compensated based on payments recovered. We anticipate these programs will be more aggressive and sustained as they demonstrate success. For example, Washington State has over 30 RAC audits currently in process. In Alaska, a large number of SURS audits are underway.

It is imperative that providers be proactive by developing plans to respond promptly and appropriately when contacted by a RAC, CERT, MIC or SURS auditor. Many regulations and laws carry severe civil penalties and fines. In addition, these types of audits and investigations invite the possibility of negative media coverage as well as the high cost of working with a payer or government agency that is conducting the audit or investigation. Rather than go it alone, *hoping* for a good outcome, consider using a qualified external firm to support your efforts and defend your facility against these audits.

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Lifestyle Funds: Target Date and Risk-Based Investment Options for 401(k) and 403(b) Plans

By William Small
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and
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Lifestyle funds are among the most often used and least understood investment options in use today. The appeal is easy to understand – pick a fund based upon when you wish to retire based upon your risk tolerance – and leave the rest to investment professionals.

In just the last few years, hundreds of these risk and date-based products have been launched. They promise the potential for consistent returns at an appropriate level of risk. The goal? Future income based upon accumulated values through growth and income. Some of the product names used (LifePath, Freedom Funds, TargetDate, LifePoints, etc.) can be confusing and frustrating for employers, employees and even some professionals.

A Well Kept Secret

Despite overwhelming adoption of such funds by plan sponsors and increased utilization by plan participants, an unanswered question in the retirement industry is exactly how much variability and inconsistency there is in the design, manufacture and distribution of these products. Further, the structure of these products has made sound fiduciary oversight more challenging than with other types of funds.

One challenge is that they may not work as intended. Like nuclear energy in the 1950's, lifestyle funds have been enthusiastically promoted and utilized, but may carry with them some unexpected and unintended consequences. It may take a while before we get all the kinks out of their manufacture and use. For some decision-makers, the help of an objective professional not affiliated with the solution vendor can help manage their risks and results.

A volatile investment environment and tepid returns for some lifestyle funds in recent years have resulted in questions about their use. Regulators, Congress and plan sponsors have asked for more understanding, standardization, transparency, disclosure and documentation of these new products.

A Lot of Money

A recent report from Casey Quirk, an institutional research firm, suggests that target-date and target-risk retirement vehicles will attract 80% of new and reallocated flows into defined contribution schemes for the next decade. We have seen significant changes in plan sponsor and participant behaviors in clients retirement plans. As the result of aggressive "educational" marketing by some vendors, plan participants have reallocated over half of their existing balances into these modern marvels.

Many plans with auto enrollment and default investment features (known as QDIAs) use lifestyle funds as the destination for participants that fail to select an investment fund. Some plans have up to 80% of new contributions going to these managed options.

A basic issue for participant-directed retirement plans (401(k), 403(b), 457, some other profit sharing and money purchase or annuity plans, etc.) is how to provide investments that meet participants' goals, objectives, constraints and preferences of each individual employee/investor.

Do it Yourself or Autopilot?

Some participants wish to self-manage their accounts through the implementation of a personal investment policy, including goal-setting, asset selection, manager selection, asset allocation, periodic oversight and rebalancing and reallocation to reflect changing personal circumstances and market conditions. That's quite an order for most employees.

Not surprisingly, many plan participants need more help, whether in the form of education, advice or someone to take on the entire management function. A well-crafted, "outsourced," solution can help a plan participant put his/her retirement investments on "auto pilot." Much of their success will be based upon the assumptions made in the design, manufacture and operation of the solution – together with the limitations of the products and the expectations of their users.

Borrow, Buy or Build?

All three options (borrow, buy or build) are available to plan sponsors. Each comes with risk, opportunity and potential returns. To help our readers understand their options, we will conduct a research project on the subject of lifestyle

funds in the coming weeks.

Healthcare finance, HR and benefits professionals will be asked a few salient questions through a simple, confidential, online survey about their current practices and results. Just five minutes of your time will help us generate meaningful data for an upcoming research report, "**Healthcare Retirement Practices: The Good, The Bad & The Ugly**."

William Small is a principal with Highland Capital Advisors in Issaquah, WA. His firm serves institutional clients, including healthcare retirement plans, throughout the Western United States. He was formerly a member of the management team at Howard Johnson and Company and Merrill Lynch Institutional Consulting. He can be reached at (425) 466-2946 or bsmall@hcportfolios.com.

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(Davenport, WA)

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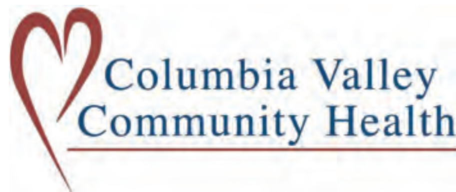

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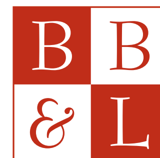

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