Oregon Chapter of HFMA

PIPELINE

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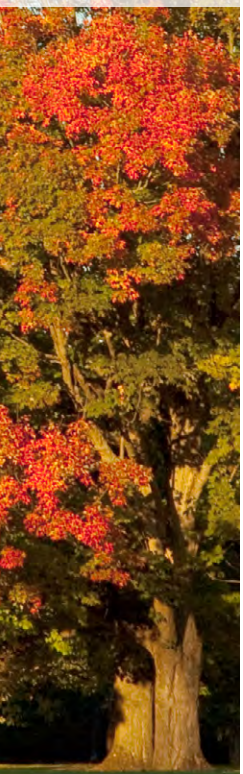

President's Message

Look to HFMA for information and education

Summer is over and fall is upon us, and health care reform continues to be in the spotlight both nationally and locally, with Oregon continuing to push the extremes. Oregon Chapter members can continue to look to HFMA as their source of information and education. During the recent joint conference with Alaska/Washington, our members were treated to topics such as ACO readiness, ICD-10 readiness and provider readiness for changes in payment systems. If you attended that conference, you helped prepare yourself and your organization for the changes that are racing toward us, no matter what happens with the upcoming presidential election.

As everyone does at the end of each year, I encourage you to look back and reflect on the past year, both personally and professionally.

First, at work: What could you have done better? I'm guessing that more emails did not come to mind first. I do think that spending more time educating yourself on upcoming changes in health care that will impact you and your organizations did. I hope in 2013 you will look to Oregon HFMA as your source of this education.

Second. personally: Again the same question — what could you have done better? Again, I'm guessing that more emails is not at the top of the list. How about spending less time on our smart phones and more time with families? My organization, like many others, is continuing to evolve our culture. One value we talk about that I personally like is a saying, "Be here now!" While I might not be successful implementing this at work, I have been very successful using this with my daughter. Yes, I can live without my smart phone, and amazingly my work can wait for me. While we live in everything now, and all information now, I recommend that you each find time in your personal life to "be here now" and unplug.

I look forward to seeing you in 2013 at Oregon HFMA education events and hearing your stories about "being here now"!

Respectfully yours,
Dustin Taylor
Oregon Chapter president

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Social networking continues to increase in popularity and importance. You may have a Facebook profile, a LinkedIn page, or a Twitter account — and so does HFMA National.

Whether you want to connect with a specific HFMA forum group or need general information, use HFMA National's official social networking site at **www.hfma.org/chapter_resources/socialnetworkinglinks.htm** to make your social networking profile count, and get connected with us!

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Medical device excise tax takes effect in January

By Patrick McConnell, CFO, West Park Hospital District

Beginning Jan. 1, 2013, there will be a 2.3 percent excise tax imposed on medical devices. The medical device vendor must pay the tax, and likely will pass it on to the customer. This tax was imposed as part of the the Patient Protection and Affordable Care Act, with the proceeds from the tax to be used to pay for the services included in the law.

At West Park Hospitals, medical devices represent about half of our total supply budget (implantable medical devices). Hospitals will feel a squeeze as our costs will be going up at a time when PPACA requires reductions in Medicare and Medicaid reimbursement.

The IRS defines a medical device this way:

> For purposes of the medical device excise tax, a device defined in section 201(h) of the FFDCA that is intended for humans means a device that is listed as a device with the FDA under section 510(j) of the FFDCA and 21 CFR Part 807, pursuant to FDA requirements. The FDA listing requirements are longstanding. Further, device manufacturers must comply with these requirements as part of the FDA's device regulation process. Therefore, device manufacturers can be expected to know which devices fall within the definition. The FDA has promulgated classification regulations for approximately 1,700 different generic types of devices. Each classification regulation includes one or more product codes that describe a subcategory of the device type described in the regulation. Currently, manufacturers may, in certain circumstances, list multiple different devices that fall within the same product code under a single listing. Therefore, all devices that are listed under a single product code listing in conjunction with the FDA's device listing requirement are taxable medical devices unless they fall within an exemption under section 4191(b)(2).

There is an exemption to the tax for items routinely purchased by the public at retail. The IRS offer this guidance:

> The proposed regulations also provide a non-exclusive list of factors to be considered in determining whether the design of a device demonstrates that it is primarily intended for use in a medical institution or office, or by medical professionals, and therefore not intended for purchase and use by individual consumers. Those factors are (1) whether the device generally must be implanted, inserted, operated, or otherwise administered by a medical professional; (2) whether the cost to acquire, maintain and/or use the device requires a large initial investment and/or ongoing expenditure that is not affordable for the average consumer; (3) whether the device is a Class III device under the FDA system of classification; (4) whether the device is classified by the FDA under certain parts or subparts of 21 CFR; and (5) whether the device qualifies as durable medical equipment, prosthetics, orthotics, and supplies for which payment is available exclusively on a rental basis under the Medicare Part B payment rules and is an "item requiring frequent and substantial servicing" as defined in 42 CFR 414.222. With regard to the regulatory classifications incorporated into the fourth factor described in this preamble, the IRS and the Treasury Department have determined, based on all the facts and circumstances, that the overwhelming majority of product codes that fall within these regulatory categories do not include devices that are of a type generally purchased by the general public at retail for individual use. Whether a device is of a type generally purchased by the general public at retail for individual use is determined based on all relevant facts and circumstances. Thus, there may be relevant facts and circumstances in addition to the factors specifically identified in the proposed regulations.

http://www.mddionline.com/article/medical-device-tax-101

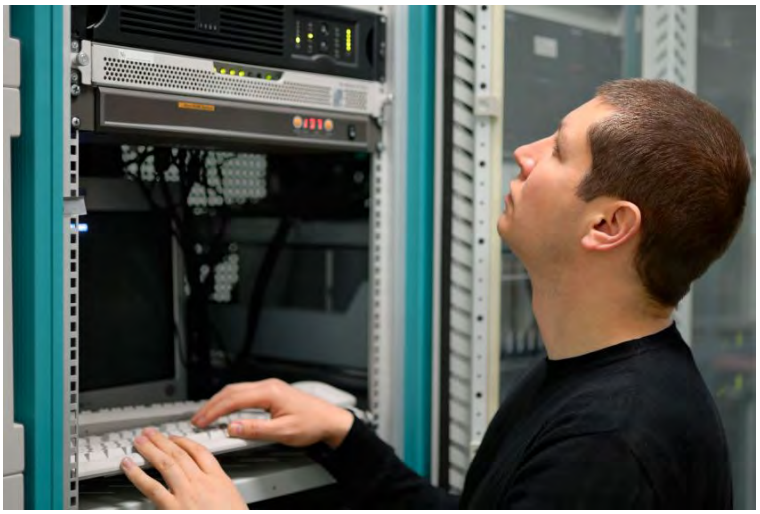
http://www.irs.gov/uac/Medical-Device-Excise-Tax:-Frequently-Asked-Questions

www.westparkhospital.org

Health information technology: Planning and financing upgrades

By Dan Mandy, Winthrop Resources, and Jason Dopoulos, Lancaster Pollard

In health care, technology is critical to ensuring patient safety and clinical quality as well as attracting and retaining qualified professionals. With the industry constantly changing, particularly with the enactment of health care reform, hospitals and health systems must strategically plan for and finance health information technology (HIT).



HIT assets in a hospital include:

- Software such as electronic health records, enterprise resource planning and departmental systems
- Imaging equipment/solutions such as MRI, CT, digital mammography, picture archiving and communication system and vendor neutral archives
- Pharmacy equipment such as automated dispensing machines and mobile cabinets
- Point-of-care solutions such as computers or workstations on wheels, wall-mounted CPUs and tablets
- The IT infrastructure that supports all of the above, including servers, storage, routers, networking equipment, radio frequency identification and Wi-Fi

It comes down to understanding the organization's HIT challenges and needs by viewing the asset or resource as part of a whole (clinical equipment, IT network, capital project, hospital, system), matching the debt structure to the asset life, as well as to the hospital's strategic goals, and then finding the best source of capital. While it seems deceptively simple on paper, it takes careful research and analysis, with input from multiple stakeholders, including representatives from both IT and clinical staffs.

What drives health technology

Health care is an industry that's in transition and evolving rapidly. It's transitioning from independent providers to coordinated delivery systems, from a fee-for-service, volume-based business model to a performance-based business model. Any discussion related to improving health care, whether reducing costs or improving patient safety and satisfaction, usually has technology as a key component. The push to leverage information technology to modernize the health care delivery system is a priority in health care reform efforts.

What macro-factors are pushing the nation's health technology evolution?

- Innovations in clinical and information technologies will continue to improve health care IT tools.
- Electronic health records (EHRs) facilitate sharing patient information, make quality reporting easier and reduce costs over the long term.
- The Patient Protection and Affordable Care Act, the primary driver of health care reform, incentivizes hospitals and health systems to adopt an EHR and electronic billing. More than 2,250 hospitals have successfully participated in the incentive program as of May 2012, according to the U.S. Department of Health and Human Services' Office of Provider Adoption Support.
- Hospital consolidations necessitate unifying what were once separate facilities under one IT system, chiefly an EHR component. There were 86 hospital merger or acquisition deals in 2011 — the highest number in a decade. The pace of consolidations is expected to continue as health care reform takes effect.
- Obtaining a competitive advantage in the marketplace. Keeping current with health care information technology can help increase patient safety and satisfaction, ensure quality medical treatment and attract top-quality clinical professionals.

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HIT upgrades

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Make IT a part of the plan

Over the last decade or so, health information technology has been getting more and more attention in the strategic planning process. Hospitals and physicians realized its growing importance in the clinical and business environments as well as the need to keep up to date with the latest innovations in software and hardware to maintain health care delivery, ensure patient safety and increase efficiency.

In addition to the usual stakeholders in a hospital's strategic planning process — leadership, board members, medical staff, department heads, etc. —care should be taken to ensure interdisciplinary coordination between clinical and IT departments, along with physician groups. The strategic planning committee will develop objectives, weigh alternatives, propose strategies and be the champions for the adoption of new technologies. Additionally, consultants for information health technology and financing also should be included in a hospital's planning process.

Because of the diversity of technologies that must be acquired from multiple IT and medical vendors, it is essential to develop an effective strategy to address technology acquisitions and management.

Because of the diversity of technologies that must be acquired from multiple IT and medical vendors, it is essential to develop an effective strategy to address the hospital's future technology acquisitions and management. Major considerations for analysis include:

- Susceptibility to change, which encompasses:
  - — Market forces: health care reform, shifting payment models, declining reimbursement, ICD-10 and other regulatory/economic forces
  - — Technology forces: IT and clinical equipment advances, updated standards, vendor trials/outcomes
  - — Hospital forces: mergers and acquisitions, recruiting/retaining physicians, market competition and financial profile.
- Ripple effects — Certain technology assets can be affected by the introduction of other assets into the facility. For example, when digital mammography is introduced, hospitals will need to consider the adequacy of current network and storage capacities, diagnostic workstations that may need to be upgraded, and additional software that may be needed, e.g., computer-aided design or other advanced visualization.
- Expected useful life of the asset:
  - — How long does IT leadership believe the technology will be effective?
  - — Will the hardware support future software versions?

Additionally, a hospital's strategic planning committee needs to look at HIT components in any planned renovation or new construction of the capital project, particularly for the hardware infrastructure considerations (wiring, server rooms, work stations, etc.). It also is important to ensure alignment between the capital project's IT components and the hospital's strategic technology goals.

Finally, the strategic planning committee is charged with recommending how the hospital will pay for resources included in the strategic plan. Options include a flexible rental model (leasing) or a long-term ownership model (cash purchase/loan). The key to determining the best financing option is to match debt to the asset's useful life, taking into consideration project scope and the lowest cost of capital available. For each option under consideration, the committee should do an analysis before making a recommendation.

Buy vs. lease

HIT assets in general depreciate rapidly and quickly become obsolete; their value is derived from their use. Hospitals are faced with the decision of which financing option makes the most economic sense.

Some technologies fit into an ownership model, but usually only if they remain useful and cost-effective for more than six or seven years. In today's low-interest environment, a hospital can acquire HIT assets with a shorter life span with a short-term bond or private placement to take advantage of the steep yield curve. This is especially feasible when done in conjunction with a renovation or new construction

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HIT upgrades

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project that uses long-term (25 years) fixed-rate financing for "bricks and sticks." Within the long-term financing structure a short or intermediate tranche of bonds can be structured to match the life of the HIT assets.

Leasing can be attractive because it can offer more flexibility in structuring cash flows and can incorporate the ability to change technology as conditions dictate. It can become an organization's "financial cloud" by paying for the use of technology without giving up control or flexibility to customize how and where technology and services are delivered.

Different hospitals will approach the buy-versus-lease decision from different points of view. Those with a heavy existing debt load may not be able to borrow additional capital and may opt to structure a lease to fit within their existing bond covenants, other hospitals may have the financial flexibility to add debt without any negative implications to their capital structure or existing debt structure. Hospital management should make a concerted effort to consult with their existing capital providers to ensure compliance with existing covenants.

Change is the new normal for today's health care organizations. Health information technology is necessary to be competitive and to provide patients with quality care. Therefore, it's imperative to have a strategy to acquire and manage HIT assets as part of a hospital's strategic plan.

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Active vs. passive investing
Redefining alpha and beta

By Adam Smith, CFA, CAIA

Active versus passive investing is a topic that institutional investors have fiercely debated for many years. While many institutions are focused on whether active or passive management is the optimal solution for the entire portfolio, a more sophisticated approach is appropriate.

Rather than focusing exclusively on one or the other, institutional investors would be wise to better understand the nuances of certain active and passive strategies. Doing so can provide an opportunity to use both active and passive as complementary solutions within an institutional investment portfolio.

Active and passive strategies further defined

Often, institutional investors define all investment strategies as either actively or passively managed. However, each of these strategies can be further defined, which can lead to differences in both expected returns and volatility.

One way in which actively managed strategies can be defined is by the number of holdings: those that are more concentrated versus those that are more diversified. Although there is no magic number that separates concentrated from diversified, concentrated strategies will typically have larger position sizes and a larger weighting in the portfolio's 10 largest positions, in addition to fewer holdings, all relative to more diversified strategies. As a result, concentrated actively managed strategies are often thought to exhibit higher conviction because the managers of these strategies are willing to put a larger amount of the portfolio into their best ideas, i.e., their highest conviction holdings.

There are also slight nuances within passively managed strategies, most of which involve how the index is constructed. Most indexes weight stocks based on market capitalization, which is the most recent stock price multiplied by the number of shares outstanding; therefore, Stock A, with a market capitalization of $5 million, would have a 5 percent weighting in an index with a total market capitalization of $100 million. Alternatively, an index might weight stocks based on dividend payments; as a result, Stock A, which pays $1 million in dividends annually, would represent just 2 percent of an index whose constituents pay $50 million in dividends annually. Passive strategies that track market cap-weighted indexes, i.e., those that are based on price, are typically known as traditional beta, while those tracking indexes that weight components based on factors other than price are commonly referred to as smart beta.

Based on data for exchange-traded funds (ETFs), most of which are passively managed, the number of passive strategies based on indexes that weight securities using measures other than market capitalization (i.e., smart beta) has increased significantly in recent years. According to a recent article in Barron's, today there are more than 1,400 ETFs, tracking more than 1,000 different indexes, while there are at least 20 different approaches to weighting and 27 different selection criteria for indexes tracked by ETFs. A decade ago, all but a few ETFs weighted companies by market cap; however, almost half of ETFs currently on the market today use a different criterion. Therefore, the proliferation of smart beta strategies provides institutional investors with another tool they can use to construct portfolios. In order to utilize each of these strategies properly, however, institutional investors must first understand the differences in expected risk and return for each strategy.

Tracking error and alpha are related

In order to understand the expected risk and return of each strategy, institutional investors must first understand the

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Active vs. passive investing

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relationship between two commonly used statistical measures: tracking error (risk) and alpha (return).

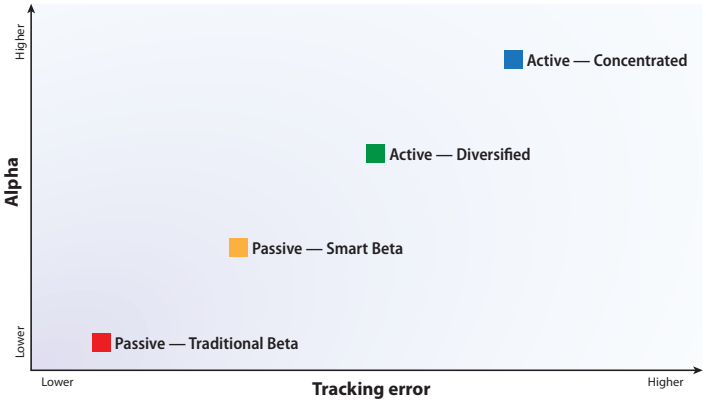
Tracking error is a risk statistic that measures the volatility of a portfolio's excess returns relative to an index. It is calculated as the standard deviation of excess returns over a period of time, such as the standard deviation of monthly excess returns over a 10-year period. Typically, a traditional beta passive strategy should generate the lowest tracking error, while a concentrated active strategy should result in the highest tracking error.

Alpha is a return statistic that measures the excess return generated by an investment above that of an index. Because passive strategies seek to track the performance of an index, only active strategies are thought to generate alpha, which can be either positive or negative.

One of the golden rules of investing is that in order to outperform an index — provide positive alpha — the portfolio must differ from the index — generate higher tracking error. Therefore, tracking error and alpha are related.

Consider this example to illustrate that concept. Instead of owning all of the stocks in an index, an active manager selects those stocks expected to outperform the index. As a result, the manager has structured a portfolio different than the index, which results in tracking error and ultimately alpha, either positive or negative. In terms of actively managed strategies, those that are more concentrated typically lead to higher tracking error when compared to those that are more diversified; therefore, concentrated strategies also have the ability to generate higher alpha as well. (See "Expected return and risk," below)

Expected return and risk



Because passive strategies track an index, most institutional investors expect them to generate low tracking error and no alpha; however, this is not the case if passive is separated into traditional beta and smart beta. Traditional beta seeks to simply replicate the performance of market cap-weighted indexes, which are those that are most representative of the broad market; therefore, traditional beta strategies typically generate little, if any, tracking error or alpha. On the other hand, smart beta strategies also seek to passively track an index; however, because these types of strategies use a different methodology to weight securities, their returns can differ from those of a market cap-weighted index. As a result, relative to a market cap-weighted index, a smart beta strategy will typically lead to a modest level of tracking error and the opportunity to generate alpha. Therefore, even though smart beta is a passively managed strategy, its weighting methodology can result in alpha, which can be positive or negative. After understanding the nuances between the various types of active and passive strategies, institutional investors can now focus on how each of these strategies can be used within a single portfolio.

Core-satellite: Combining active and passive

By redefining the concept of active versus passive, institutional investors can use all four strategies within their investment portfolio by implementing a core-satellite approach. Core strategies are typically those that are well diversified and provide broad exposure to an asset class, while satellite strategies complement a core strategy by providing the opportunity to generate alpha.

Traditional beta is typically best used as a core approach because it results in the lowest tracking error and provides the broadest exposure to an asset class. Conversely, concentrated active is used exclusively as a satellite approach because it has the highest amount of tracking error and typically results in the highest alpha as well. Therefore, a combination of the two should result in a market-like return from the traditional beta strategy complemented by the alpha generated by the concentrated active strategy. Smart beta and diversified active strategies can serve as either core or satellite approaches, depending upon the

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Active vs. passive investing

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asset class; however, institutional investors should refrain from using traditional beta strategies as a satellite approach or concentrated active strategies as a core approach. This is because traditional beta strategies do not generate the alpha required of a satellite approach and concentrated active strategies do not provide broad exposure to an asset class because they result in too much tracking error.

Rather than broadly defining active and passive, institutional investors would be better served by differentiating diversified from concentrated within the actively managed portion of their portfolio and traditional beta from smart beta within the passive portion. Doing so should allow institutional investors to better understand the risk and return expectations of each strategy, as defined by tracking error and alpha, thereby allowing these different strategies to be used as complementary solutions within an institutional investment portfolio.

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UPCOMING EVENTS

Winter Meeting 2013
February 20–22
Embassy Suites Portland–Washington Square
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Spring Meeting and Annual Banquet 2013
May 15–17
Salishan Spa & Golf Resort
Gleneden Beach, Ore.

Summer Meeting 2013
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Health care reform

The future holds challenges and opportunities for providers

By Peter A. Pavarini, Squire Sanders LLP, and Matthew J. Lindsay, Lancaster Pollard

In late June the Supreme Court of the United States narrowly ruled that the Patient Protection and Affordable Care Act, commonly referred to as the Affordable Care Act or ACA, was for the most part constitutional. Now that the high court has ruled in favor of this major reform of the nation's health care system, we have some answers — but just as many questions — regarding its impact on providers.

Now that the Supreme Court has ruled in favor of health care reform, we have some answers — but just as many questions — regarding its impact on providers.

Let's take a look at the law, and the Supreme Court's decision, to determine what challenges and opportunities are ahead for health care providers. In particular, how might the ACA, as interpreted by the Supreme Court, affect borrowers' access to capital in the future?

A sweeping law and a landmark decision

The ACA, which was enacted in 2010 and is being implemented over several years, was primarily intended to decrease the number of uninsured Americans —17.1 percent in 2011, according to a Gallup poll — and reduce the cost of health care over time by making a variety of changes to how providers are paid. It provides both incentives and penalties to employers and uninsured individuals in order to increase insurance coverage. Under the law, the federal government will also expand Medicaid, so that about half of all uninsured people gain coverage. Additional reforms of this far-reaching legislation are aimed at improving health care outcomes in the United States while increasing the efficiency of health care delivery.

The Court's decision upheld the ACA's individual mandate, the requirement for nearly all Americans to secure health insurance, as a constitutional application of Congress's taxing power. Because the mandate survived the constitutional challenge, the remaining parts of the law were affirmed, including the requirement that payers insure all applicants regardless of their health status and the prohibition against charging customers more because of pre-existing conditions or demographics.

However, the court ruled that states must be allowed to opt out of the ACA's Medicaid expansion without losing their pre-existing funding. It remains unknown how many states will participate in the Medicaid expansion or establish their own insurance exchanges, but some have already expressed their intention to decline one or both of these opportunities.

Impact on the industry

The immediate effects of the court's ruling on the health care sector have not been dramatic. For the most part, the decision was seen as a credit-neutral event by the Big Three credit-rating agencies: Standard & Poor's, Moody's Investor Service and Fitch Ratings. Although they differ in whether they view the law as positive or negative, the rating agencies generally expect rated borrowers to have sufficient time to manage these reforms with little effect on their credit quality, at least in the near or midterm.

Despite the uncertainty generated by the pending Supreme Court decision, the private sector had been preparing, albeit slowly, for the eventual enactment of the ACA. With resolution of the constitutional issue, the attention now turns to the November 2012 elections and whether

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Challenges and opportunities

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any change in the White House or Congress could again leave Americans wondering about their health coverage.

Notwithstanding the unsettled nature of the political situation, health care providers understand that their former ways of doing business are bound to change no matter what happens in Washington. Of greatest consequence is the expectation that future provider revenues will have less to do with patient volumes and more to do with clinical outcomes, quality and cost-efficiency. Providers that get good results for their patients and keep costs in check stand to be rewarded with performance bonuses, shared savings and other revenue enhancements. Those providers that fail to do these things can expect financial penalties that will affect revenues and ultimately tarnish a provider's credit profile. "Accountable care" may still be gestational in most areas of the nation, but the concept appears to be taking hold and will eventually replace large portions of our existing fee-for-service system.

Hospitals and health systems

As the ACA's health insurance provisions kick in, a drop in the number of uninsured patients could result in a significant reduction in a hospital's charity caseload as well as its bad debt. But hospitals should continue to approach how they bill patients eligible for financial assistance very carefully. ACA does not relieve hospitals of the duty not to charge such patients artificially high prices nor does it change the fair collection requirements of prior law.

On average, Medicare and Medicaid patients account for more than 50 percent of the care provided by hospitals. Any expansion of these programs is likely to be a two-edged sword for hospitals. While more patients may end up being covered, declining reimbursement and greater risk-sharing with providers could offset any budgetary gains. Hospitals will need to pay as much if not more attention to their payer mix as well as to how they set and manage rates.

In the pursuit of improved clinical outcomes, growing importance will be placed on preventive health services. Greater clinical and financial alignment between hospitals and primary care physicians will be necessary if payers demand and reward lower cost alternatives to expensive hospital stays.

Hospitals also will increasingly need to provide or contract for a broader spectrum of care to manage population health in their communities. It will no longer be acceptable for hospitals to give their patients a list of post-discharge providers and then leave them to fend for themselves. If a hospital bears some responsibility for what happens to patients after they leave its facility, there will be a continuing duty to see that post-discharge care is provided in the most appropriate and least expensive setting. This aspect of accountable care will provide hospitals with an opportunity to diversify revenue by acquiring other providers along the continuum of care, e.g., home health businesses and skilled nursing facilities.

Additionally, in order to maintain their favored status, tax-exempt hospitals will be required to conduct a community needs assessment every three years, then adopt and implement a strategic plan that meets those needs identified by the assessment.

Skilled-nursing and assisted-living facilities

Impending reimbursement cuts will threaten profitability as most of the revenues from skilled-nursing and assisted-living facilities are from Medicare and Medicaid. To reduce costs, the new law also encourages patients to receive home-care services, which are less expensive than receiving skilled-nursing or assisted-living care. To remain profitable, facilities may have to raise prices for private-pay patients to offset the losses from government reimbursements.

To prepare themselves financially for health care reform, General recommendations for skilled-nursing and assisted-living facilities include changing business models to diversify revenue streams, bundling services and contracting with larger providers. However, to succeed at accountable care, facilities will need to successfully manage high acuity care at a lower cost and to reduce hospitalizations.

Access to capital

At present, the Supreme Court's decision appears to be bringing a measure of stability to the bond market as evidenced by an increase in new money issuance. Hospital providers that have delayed capital spending for the past few years are now reconsidering entering a favorable interest-rate market. With an increased appetite from

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Challenges and opportunities

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investors for tax-exempt bonds, conditions are favorable for hospitals to achieve a lower cost of capital.

A recent example of this was Kennedy Health System of Cherry Hill, N.J. The 596-bed, multi-campus hospital took advantage of the strong health care market for rated credits to issue $66 million in tax-exempt revenue and refunding bonds. A part of the proceeds will finance new projects. The market responded positively to the offering, so much so that the hospital obtained improved pricing as a result of high demand. The result was an exceptionally low cost of capital while preserving maximum flexibility for the borrower.

In general, capital will be more available to investment-grade hospitals and health systems and continuing care retirement communities. As health reform progresses, credit ratings may be more difficult to maintain given the anticipated decline in hospital volumes which should result in thinner profit margins. In addition to an organization's credit profile, credit-rating agencies will look at quality factors, such as outcomes, much more closely than they have in the past.

The ACA has ramifications for all aspects of the health care sector as well as the broader economy. However, with a careful understanding of and preparation for this historic piece of legislation, health care providers will be better prepared for the impact of health care reform on their financials and future access to capital.

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