The Chesapeake Bay Line

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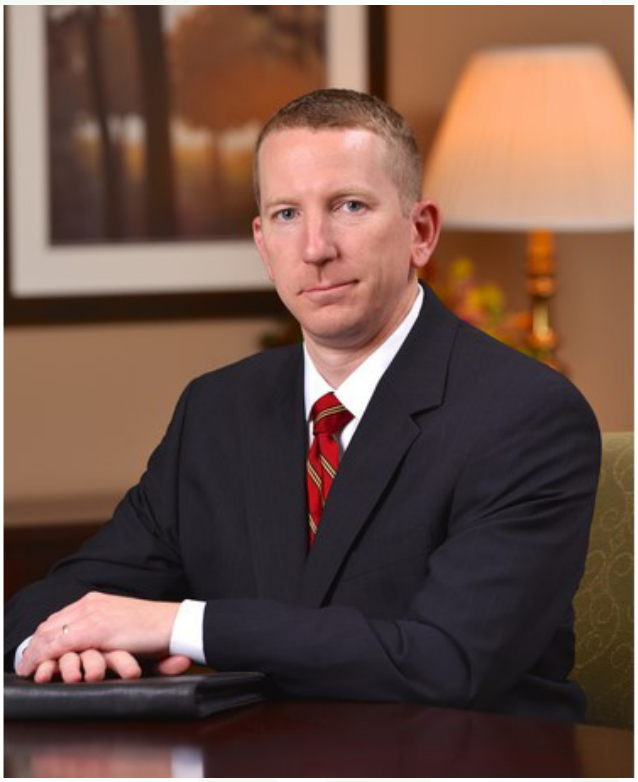
Officer's Corner

Brett McCone
Maryland Hospital Association
Maryland Chapter HFMA President-Elect



Greetings fellow chapter members! It's an exciting time to be in our field and a great time to be a member of the Maryland Chapter of HFMA. Though tumultuous at times (witness DC, Washington), now more than ever, financial leaders are needed at every level across all types of organizations. Whether a large multi-hospital system, small physician practice, health plan, technology solution, or anything in between, chapter members are creating the vision, implementing operational changes and revolutionizing the field. Being part of this journey carries great responsibility and even greater reward.

Here in Maryland, we are four months into the fourth year of our All-Payer Model demonstration with the Centers for Medicare & Medicaid Innovation. By January 1, 2019, Maryland must reach a new agreement with CMMI to continue the demonstration. Over the past three years, hospitals, health systems, insurers and physician practices are converging to achieve the triple aim – improving the health of the population, improving the patient experience and lowering costs.

Several years ago I had the pleasure of explaining the new incentives to a local health system's Board of Directors. Gone are the days of looking forward to the flu season to drive marginal hospital volume that would improve the bottom line by year end. Instead, simple solutions like providing everyone in the community flu shots can keep people healthy, avoiding expensive hospital care, allowing for new investments to improve health. We've done "care" extraordinarily well for fifty years, and it will always be an important part of our mission. How we achieve "health" for the next fifty years will be an equal measure.

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What's Inside...

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New Revenue Procedure Is Here To Stay

By Andrew Kloeckner (akloeckner@bairdholm.com) and Bill Wilson, Senior Vice President (bwilson@lancasterpollard.com) with Lancaster Pollard

Out with the old and in with the new? A recent revenue procedure change is catching the attention of health care providers with facilities financed through tax-exempt bonds. The good news is, the changes allow for greater flexibility and revised safe harbor guidelines.

The Internal Revenue Code (IRC) provides that interest on bonds issued by governmental or 501(c)(3) organizations may be exempt from tax if, in addition to satisfying other requirements, not more than 10% of the proceeds of the debt issuance for governmental entities (5% for 501(c)(3) organizations) are utilized in a private business use (a private party such as a medical practice or for-profit service provider may qualify as a private business use). As a result, traditional service agreements between hospitals and medical practices and other arrangements to manage segments of hospitals' businesses may be considered management agreements and could cause financings to fail the private business use test. This would result in interest on bonds being taxable.

In order to prevent such a result, hospitals with outstanding tax-exempt debt historically sought to fit management and service agreements into one of a multitude of complex and often burdensome private use safe harbors under the Internal Revenue Service (IRS) Revenue Procedure 97-13 (Rev. Proc. 97-13). These safe harbors were tied to the length of the agreement and the type of compensation provided to the service provider. If a safe harbor was satisfied, then the agreement would not qualify as a private business use.

Because the safe harbors were extremely technical and complex, on August 22, 2016, the IRS issued Revenue Procedure 2016-44 (Rev. Proc. 2016-44) as a replacement to Rev. Proc. 97-13. Rev. Proc. 2016-44 has been lauded in the industry as providing greater flexibility for management and service agreements to qualify for private use safe harbors. Gone are the rigorous tests of the past that tie modes and forms of compensation to the length of agreements.

However, in the health care context, while the modes of compensation and lengths of agreements have been liberalized, there are a few provisions in Rev. Proc. 2016-44 that are likely to be viewed as more restrictive than Rev. Proc. 97-13 and may be viewed by clients as unnecessary or prohibitive in securing needed physician services. There are also numerous outstanding questions caused by the vagueness of the safe harbor as it relates to typical health care contracts.

New Safe Harbor Provisions

For a management or service agreement to fit within Rev. Proc. 2016-44, the following elements must be satisfied:

- **Reasonable Compensation:** The compensation paid to the service provider must be "reasonable" for the services rendered. Instead of analyzing whether the compensation methodology is a periodic fixed fee, per unit fee or percentage of revenue or expense fee, now, the compensation must only be reasonable.
- **No Net Profits or Losses:** As before, compensation cannot be tied to the net profits or net losses of the hospital or any service line or department of the hospital. Importantly, for purposes of many alternative payment methodologies and accountable care organization (ACO) activity, incentive compensation based on meeting quality, performance or productivity standards is not considered to be based on net profits. Likewise, compensation tied solely to revenue or expenses, but not both, may be permissible. However, provisions that delay or subordinate payment of fees to profitability or availability of funds can be viewed as a "net profits" arrangement.
- **Risk of Loss:** The service provider cannot bear the risk of loss due to damage or destruction of the hospital or managed property.
- **Term:** The term of the agreement may be no greater than the lesser of 30 years or 80% of the weighted average of the reasonably expected economic life of the property subject to the agreement. This is a significant lengthening of the typical safe harbor contract terms relied upon by hospitals under Rev. Proc. 97-13. However, as further described below, this provision can be a significant impediment if the property being financed is older or otherwise close to the end of its useful life, which may be the case in many refinancings.
- **Control of Property:** The hospital must control the financed property. This means that the hospital must retain authority over matters such as approval of budgets, capital expenditures, disposition of property, rates charged for use of the property, and the general nature

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Certification News

Linker Mills, FHFMA, CRCR
Maryland Chapter Certification Contact

I am proud to announce that Thomas Cassel, Senior Financial Analyst at Bon Secours Health System, became a Certified Healthcare Financial Professional (CHFP) back in November. Congratulations Thomas!

In addition, we have had several of our CHFP members become Fellows of HFMA (FHFMA) in the last several months. This deserves recognition as this means going above and beyond being certified. These individuals have given back to the health care community through volunteer work and have been members of HFMA for a minimum of five years.

Congratulations go out to our newest Fellows:

- Desiree Axley, Director of Finance at MedStar St. Mary's Hospital
- Daniel Cochran, Chief Financial Officer at Shady Grove Medical Center
- Dr. Olakunle Olaniyan, President of Case Management Covenants

It has been my pleasure being your Maryland chapter certification contact for the last five years. I'm handing over the reins to Chuck Cronauer, who many of our newer members know as our volunteer service coordinator. I'll still be around assisting Chuck as needed, so feel free to reach out to me as a secondary contact for any certification questions.

A reminder that if your employer does not pay for the CHFP certification program, your Maryland HFMA chapter will reimburse Maryland Chapter members once you become certified.

If you have any questions relating to certification, please feel free to call me at 443-777-7949 or email me at linker.s.mills@medstar.net.

Let Yourself Be Heard!

Attention all members, sponsors and friends of the HFMA Maryland Chapter.

Have something to say
to the Maryland Chapter members?

Itching to share your thoughts with others?

Then write an article for
the Chesapeake Bay Line.

Send your articles for consideration
to Donnell Henry, Newsletter Chair at henryd@kennedykrieger.org

Booming Demand: How Urgent Care Centers are Impacting Hospital Operations

By Conner Girdley Vice President (cgirdley@lancasterpollard.com) and Keith Jones Summer Associate with Lancaster Pollard

The construction and use of urgent care centers in the health care industry has steadily increased over recent years. The growing popularity of urgent care centers presents an opportunity for hospitals to extend networks or expand partnerships in order to reach new clientele. Further, it offers an opportunity to enhance brand recognition in new and existing markets.

According to the Urgent Care Association of America (UCAOA), urgent care dates back to the late 1970s and was created with the intention of meeting a community's immediate health care needs. It was a slow but steady start for urgent care in the beginning, but the concept of seeing a physician without an appointment eventually began to gain popularity among patients. Over the past 20 years, the urgent care industry has continued to expand and earn the trust of those seeking a safe and affordable place to receive medical attention.

According to UCAOA, urgent care centers reported an average of nearly 12,000 patient care visits for the 2015 Fiscal Year.

Today, urgent care centers are physician-staffed and typically offer extended hours (evenings and weekends), providing quality care without the costs and wait times associated with the average emergency room (ER) visit. Urgent care centers are best suited for situations that require more immediate attention; often times, this serves to be more practical than seeing a primary care provider, who can be challenged with offering consumers the hours or immediacy an illness or accident can demand.

Why the Increase in Popularity?

There are various drivers behind the recent growth of urgent care. The UCAOA estimates that growth has been steady the last several years, as between 300 to 600 urgent care centers are added per year, resulting in the current population of around 7,400 centers. Challenges on the supply side, such as difficulty in finding a primary care provider and the increase in costs associated with ER visits, are a factor in the increase. A larger demand by consumers for convenience, both in terms of proximity and hours, has also resulted in a need for more urgent care centers. More recently, lenders and investors have recognized the success of the urgent care model and have begun to look for opportunities to participate in the ongoing growth.

The business model is based on low-margin, high-volume care, as the average visit costs $150 with a total visit time of under 60 minutes in 84% of cases, compared to an ER visit that averages $1,354 and consumes four hours of wait time. Costs are much lower in an urgent care setting, as detailed with some of the more commonly treated ailments shown in the chart[1] below:

Condition	ER Cost	Urgent Care Cost
Sore Throat	$525	$94
Sinusitis	$617	$112
Urinary Tract Infection	$665	$112
Strep Throat	$531	$112

An easy conclusion to reach would be that an urgent care center would draw lower-acuity patients away from emergency rooms, resulting in less overcrowding of the ER and improved efficiency. However, a study presented in April, 2016 by Grant Martsolf, et al, found that retail clinics opened near emergency departments are not associated with a material reduction in low-acuity emergency department visits. This data supports the notion that urgent care centers prompt patients to seek care for conditions that might have been treated at home or at a primary care office. Thus, urgent care centers may not be an avenue for reducing ER overcrowding, but may provide an opportunity for accretive revenue through partnership or expansion.

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Officer's Corner

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Many of you have heard me say "it's always the STP in organization that get it done." STP – the same ten people. Depending on the size of your organization, this might be the same twenty people, the same thirty people or the same two people. Even if it's the same two people, rest assured that one of them is more than likely an HFMA member. If you've been tapped to lead a new project, book revenue for month end or interpret the latest regulations, you're part of the STP, and your relationship with HFMA can help you do whatever is called for to the best of your ability.

As your president elect, I look forward to partnering with the other officers, directors and committee chairs to plan the 2017 – 2018 Chapter year. On April 23, your leadership team will travel to HFMA's annual Leadership Training Conference (LTC). This year's LTC is in Phoenix, Arizona. The chapter leaders and I will outline the strategic direction for the upcoming year. With constant change in our field, your leaders are challenging one another, and you, to develop a relevant education calendar, to find your organization's speakers that are "hidden gems," and to share knowledge with one another and with others in the field.

In the chapter, we are constantly improving, adding new volunteers, new leaders and implementing a vision to change the STP. To paraphrase John F. Kennedy, "ask not what HFMA can do for you, but what you can do for HFMA." Twenty years into to the field, I will guarantee that the investments that you make in the chapter will yield huge (YUGE!) returns for your organization and your development. Planning an education session, volunteering at a community service event, opening doors for new members or becoming a Certified Healthcare Financial Professional are just a few ways you can help lead the chapter, build your career and enhance relationships with other high performers.

Current President Michelle Brandt deserves a special thank you for leading the Chapter this year. Michelle is an outstanding leader, someone who is dependable, pragmatic, kind and thoughtful. Your chapter leaders will strive to build on Michelle's legacy, and the legacy of many dynamic leaders before her. I look forward to seeing all of you at an education session or networking event in the upcoming year. If you don't see something that appeals to you, let us know! If you've been to every session in the past ten years, or you haven't attended a session recently, everyone's opinion counts. Please let us know how we can serve you, or better yet, please come help serve others in the chapter.

Cheers and best wishes for the upcoming 2017 – 2018 Chapter Year!

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WWW.HFMAMD.ORG

**for upcoming events,
industry news and more!**

New Revenue Procedure Is Here To Stay

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and type of use of the property.

- **Inconsistent Tax Position:** The service provider must formally agree that it will not take an inconsistent tax position with regard to the agreement and managed property, for example, by taking amortization or depreciation expense write-offs as if it owned the property.
- **Relationship of Parties:** The safe harbor requires that there be no circumstances (on a fact and circumstances basis) that would effectively prevent the hospital from exercising its rights under an agreement. Rev. Proc. 2016-44 states that safe harbors that provide an arrangement will not be viewed as violating this term so long as:
  - No more than 20% of the voting power of the hospital's board rests with directors, officers, shareholders, employees, etc. of the service provider;
  - The chief executive officer (CEO) or chairperson of the service provider does not sit on the hospital's board; and
  - The CEO of the service provider is not also the CEO of the hospital or any related parties of the hospital.

Potential Road Blocks

While Rev. Proc. 2016-44 does make some substantial improvements over Rev. Proc. 97-13, there remain a few significant outstanding questions.

To maintain control of the property, hospitals must approve of the rates charged for use of the property. Under Rev. Proc. 97-13 there was a well-known split of opinion over whether hospitals were required to actually approve of the fees charged by physicians to patients. However, within the confines of Rev. Proc. 97-13, that issue only mattered insomuch as the hospital needed to use a "per unit" fee safe harbor. Under Rev. Proc. 2016-44, to receive protection of the safe harbor, an agreement must provide that the hospital approves the rates charged by the service provider (physician). This applies to any service agreement needing safe harbor protection, regardless of whether the compensation is a periodic fixed fee, per unit fee, or no fee at all. In the past, many split-bill arrangements only gave hospitals the right to review and potentially object to the physician's fees, if any rights were given at all. Express approval by the hospital is now required.

Further, while the potential length of permissible management contracts has been significantly extended, a question remains over the usefulness of this safe harbor for new management or service agreements that are entered into later in the useful life of the financed property. For example, if a hospital has bond-financed assets that are well into their useful lives (say the facility is 35-years-old and has a useful life of 40 years) and the radiology group wants to enter into a five-year agreement, the arrangement would technically not satisfy the safe harbor since the limit would be 80% of the remaining useful life (four years).

Many hospitals include physician members on their boards. One instance where this could be a problem is when a physician who is the head of a practice group with which the hospital has a contract is elected to the hospital's board after the agreement is executed. Likewise, it could arise where the chief of staff has an ex officio position on the hospital board and the newly elected chief of staff has a leadership role with a contracted group. These circumstances do not in and of themselves eviscerate the Rev. Proc. 2016-44 safe harbor, but they remove the "substantially limiting the exercise of rights" safe harbor and move the analysis to a facts and circumstances test.

These outstanding questions affect health systems and their counsel as they work to contract with physicians and physician groups for needed services. They also impact due diligence and review standards for bond counsel and underwriters as hospitals seek to go to market. While Rev. Proc. 2016-44 does lessen the structure surrounding management safe harbors in some very important ways, it also may make contracting with physicians and physician groups more burdensome than before.

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This widening of a hospital network may increase referrals and retention of patients who will seek care through urgent care centers and might find themselves referred to physicians or testing facilities within the network. If a hospital invests in quality care and branding, the uniformity of care provided in an urgent care setting will enhance a patient's overall experience and may engender confidence in the entire health care system, prompting patients to utilize other services of the hospital.

How Hospitals are Getting Involved

For hospitals interested in expanding their network to include urgent care centers there are several options. Some hospitals have pursued partnerships with an existing provider of urgent care services. This allows the hospital to step into a relationship with an existing provider that has experience in managing the low-margin environment that demands a unique staffing approach. This partnership has benefits for both the urgent care provider and the hospital because the provider receives benefits from the local hospital's brand recognition and gains access to physicians employed by the hospital. In return, the hospital benefits from a reduction in initial investment requirements and receives another referral source. It is estimated that the majority of urgent care centers in the U.S. continue to be operated as free-standing facilities, while 20% are owned solely by hospitals and another 15% are structured as joint ventures. Hospitals that pursue the partnership model must be aware of the challenges that come with information sharing beyond their existing network.

Hospitals that opt to open urgent care centers have the ability to target neighborhoods and demographics that are either underserved or have a potentially advantageous payor mix. The hospital's brand recognition can provide immediate legitimacy to the start-up centers and these centers have the ability to share complete patient information, ensuring a seamless patient experience. Hospitals pursuing this path must ensure that staffing and the scope of care provided do not tarnish the hospital's brand in the initial stages of the learning process. Traditional sources of financing for nonprofit hospitals, such as tax-exempt bonds, the U.S. Department of Housing and Urban Development (HUD)/Federal Housing Administration (FHA) Sec. 242 program, the U.S. Department of Agriculture (USDA) Business & Industry or Community Facilities program, or bank direct purchase financing, are typical options for financing these assets on a standalone basis, or as part of a larger strategic plan.

As demand for lower-cost alternatives to care that do not sacrifice quality continues to grow, opportunities for hospitals to expand into the urgent care center environment will continue to present themselves. Hospitals can act on these opportunities to grow market share and expand brand recognition, while simultaneously meeting patients' needs and providing quicker, lower-cost care than that offered in a typical ER setting.

Want to become a member or learn more about membership?
Visit www.hfmamd.org or
contact Katie Eckert at Katie_Eckert@bshsi.org.

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The HFMA Maryland Chapter has many exciting committees that would welcome your participation. If you are interested, please contact one of the Committee Chairs below:

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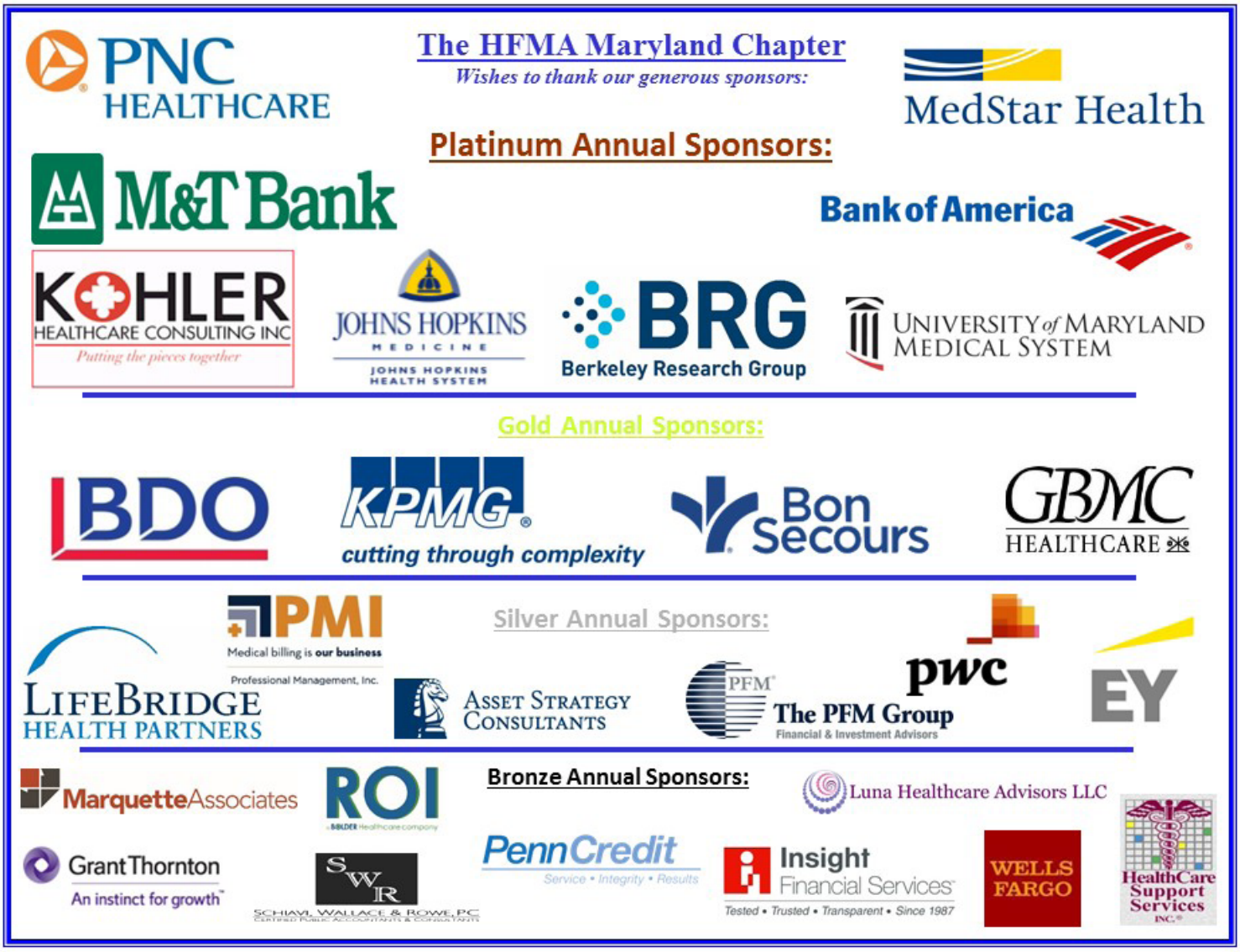

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