

*inside*

### **Latest News Reports**

- *Insurers Fall Short on Meeting New Healthcare Law's Med/Loss Ratio*
- *Will Healthcare Reform Boost Medical Tourism?*
- *Physician Report Cards: Do They Make the Grade?*

### **Research Report**

*Who's Who in Merge Healthcare, Incorporated and AMICAS, Inc.*

### **Special Report**

*People to Watch in Healthcare Transactions in the Southwest – 2010*

### **Worth Reading**

*Hospitals Turnaround – Lessons in Leadership*

### **Special Report**

*Outstanding Healthcare Fraud & Compliance Lawyers – 2010*

### **In Focus**

*Health Management Associates*

# Nightingale's Healthcare News

May 2010

Volume 8, Number 5

## **Health Reform To Change Med/Loss Ratio What's Considered Patient Care Up for Discussion**

*by Lisa Jaffe Hubbell*

A nurse calls a diabetic patient to remind her of an upcoming appointment to get her eyes and feet checked. Does that count as patient care? What about a pamphlet about poly-pharmacy sent to patients who are on more than three medications? Is that an administrative cost or patient care?

That's the question that health plans need to be asking themselves right now. Come January 1, the new health reform law requires a medical loss ratio of 80 percent for small health insurers and 85 percent for large companies. That means the proportion of premiums spent on patient care and quality improvement activities has to reach that level or the company will have to refund premiums to clients, says Scott Golden, CFO and Co-founder of the

*continued on page 2*

## **Healthcare Reform's Ripple Effect Will Patients Look Overseas for Care?**

*by Steve Raphael*

Will the new healthcare reform law encourage millions of Americans to look elsewhere for their medical care? Opinion is mixed.

"The medical tourism industry is welcoming President Barack Obama's new health care reform law with a smile that would make a Botox doctor proud," wrote Mariana Martinez, a columnist for *La Prensa San Diego*.

Not so fast, says Irving Stackpole, a Brookline, MA, health consultant. While the healthcare legislation is causing quite a big buzz among the medical tourism industry, Stackpole, President of Stackpole & Associates, isn't as convinced, calling the legislation's impact a mixed bag "as it is simply too early to tell."

*continued on page 2*

## **Making the Grade Physician Report Cards Can Be Effective**

*by Lisa Jaffe Hubbell*

Is there a doctor anywhere in the country who likes the idea of public report cards of their quality and cost performance? It's doubtful. And many were probably jumping for joy at recent peer-reviewed articles that found they didn't really impact physicians' performance or patient outcomes that much – at least not if a payer was looking at costs or quality at your average sized practice.

The most recent study, published in March in the *New England Journal of Medicine*, found that, as often as a fifth of the time, physicians participating in a cost-based profiling system were misclassified, and nearly 60 percent of the physicians had cost profile scores that were statistically considered "sub-optimal" in reliability.

*continued on page 4*

## Med/Loss Ratio, *from page 1*

health benefits firm Golden & Cohen in Washington, DC.

The National Association of Insurance Commissioners (NAIC) and the National Association of Insurance Underwriters (NAIU) are among those who are sitting at the table with health department officials trying to determine what constitutes patient care and quality improvement efforts and what doesn't. Eventually, their discussions will result in a proposal on which health plans and other interested parties can comment. A final rule is to be in place by the first of the year. Given open enrollment is in November and most plans have to give at least 30 days' notice for rate changes, this is coming down the road at freeway speeds.

Why be concerned? Most of the big players are falling short, particularly in the individual and small business markets. A Commerce Committee report from mid-April showed the following med/loss ratios for 2009 for the six largest health insurers:

- Aetna: 75.7 percent individual; 84 percent small group; 87.2 percent large group
- CIGNA: 88.1 percent individual; 92.1 percent small group; 85.2 percent large group
- Coventry: 71.9 percent individual; 78.2 percent small group; 86 percent large group
- Humana: 68.1 percent individual; 80 percent small group; 88.2 percent large group
- UnitedHealth: 70.5 percent individual; 81.1 percent small group; 83.3 percent large group
- WellPoint: 74.9 percent individual; 81.2 percent small group; 84.9 percent large group

The average for all six shows only in the large group area do they meet the requirements of the law as it stands. The entire report can be seen at [http://commerce.senate.gov/public/?a=Files.Serve&File\\_id=42805d51-b2a7-4cec-8a65-b13d61de9cbf](http://commerce.senate.gov/public/?a=Files.Serve&File_id=42805d51-b2a7-4cec-8a65-b13d61de9cbf).

Several things remain unclear. Is the ratio related to each individual client, or for the aggregate? Golden asks. "Most of what I've seen written on it indicates that it will be individually based, and refunds will go to the individual." Other questions include whether small group carriers will count the block of business, or each group.

There is also a question about how viable business will be for insurance companies once the law comes into effect. "If you make it a medical loss ratio of 80 percent, then administration and other costs may end up leaving nothing left for profit." A lot will depend, he says, on what costs currently considered administrative will be able to fit into patient care.

The other side of the equation is premiums. No one seems to know whether taxes and fees will be included in the premium number. Mark Lutes, a partner at EpsteinBeckerGreen in Washington, DC, says he doubts whether there will be a lot of commentary on the denominator part of the equation.

Some of the points that plans need to consider making when they get the chance to comment include keeping preventive services out of claims. "It's big, but it's logical." Golden says. Lutes says to pay attention to cost accounting related to emerging classifications. "They will have used methodologies for cost classification appropriate in other contexts, such as financial statements. They must now be sure that their expenditures related to quality and health improvement don't end up excluded from the numerator of the federal calculations because of other conventions."

Attorney Ken Yood, a partner at the Los Angeles office of Sheppard Mullin says you should be evaluating every single cost and seeing whether it can be recategorized as patient care. WellPoint recently reported they've found 1.6 percent of costs they can recategorize. "It might not sound like a lot, but it means millions of dollars shifted from

*continued on page 4*

## Ripple Effect, *from page 1*

Medical tourism is on the rise, and is expected to continue to increase this year as people pursue elective procedures not typically covered by health insurance, notably surgeries for facelifts and breast augmentation, as well as dental care. In Stackpole's estimation, these procedures attract as much as 40 percent of the medical tourism business. According to Health-Tourism.com, an online medical tourism guide, medical tourism is a \$20 billion-a-year industry – a figure that's expected to grow to \$100 billion by 2012.

Medical tourism advocates say their services align perfectly with President Obama's vision of what constitutes outstanding health care: cost reduction, choice, and affordability.

Cost and service are driving the trend, says Dale Van Demark, an attorney with EpsteinBeckerGreen. Patients can save from 40 percent to 80 percent on treatment, adding that tourism is "ancillary" to medical tourism. Jessica Johnson, Operations Director of the Medical Tourism Association (MTA), says that as healthcare cost continue to climb in the U.S., a growing number of insurers and employers will push people overseas. "We are already seeing a huge increase in activity from self-funded employers and insurance agents."

Medical tourists have historically sought care in Europe, Asia, and Mexico. Mexico is and will continue to be a major destination for Americans living in the Southwest, notably many of Hispanic/Mexican origin, Martinez says.

Nonetheless, worries about medical tourism persist. At a Senate subcommittee hearing on aging, the United Steelworkers raised concerns about healthcare outsourcing, including questionable quality and the lack of legal recourse should the patient become the victim in a botched procedure.

There are other perceived drawbacks as well. In a September bulletin of the American Association of Retired Persons, Dr. Anmol Mahal, President of the California Medical Association and a graduate of New Delhi's All India Institute of Medical Sciences, expressed concern about patient care being split between locations thousands of miles apart. "My perspective as a physician is that all patients should receive care for their illnesses close to home, close to their loved ones, and with a hospital and a doctor that they've grown to develop faith in and have a relationship with. That's really the ideal circumstance."

Lastly, at a time when more and more illnesses and diseases, such as cancer, asthma, and diabetes, are treated as chronic illnesses, constant trips overseas could be prohibitively expensive.

Entrepreneurial facilitators, insurers, and foreign-backed medical tourism offices are trying to counter the perspective that overseas treatment is inferior by creating well-credentialed provider networks, many of which are available for viewing at the Internet sites of the host nations. Prestigious medical institutions and providers, such as Duke University, Harvard University, and the Cleveland Clinic are creating professional relationships with overseas providers that should assuage anxious patients.

On another front, PPOs are developing overseas networks and more overseas facilities are receiving accreditation from the Joint Commission International (JCI) that works in association with and similarly to the Joint Commission on Accreditation of Healthcare Organizations. JCI has accredited more than 120 facilities in at least 20 countries, including hospitals, labs, long-term care facilities, rehabilitation centers, and medical transport

*continued on page 8*

# Research Report

## Who's Who in Merge Healthcare, Incorporated and AMICAS, Inc.

by Francoise C. Arsenault

*Merge Healthcare, Incorporated (Merge Healthcare) develops healthcare information software solutions that automate healthcare data and diagnostic workflow and delivers related services in the United States and internationally. The company's products include Fusion RIS/PACS MX, which automates image and information workflow for various imaging practices; eFilm Workstation, a desktop diagnostic image and analysis tool for viewing and interpreting medical images; The Frontiers AIMS, a peri-operative management solution that builds an electronic record of the patient's surgical experience while allowing the anesthesiologist to maintain patient contact; and EDC, IVR/IWR, and eDiaries, products sold via a software-as-a-service model which coordinate data capture, logistics, patient interaction, and trial management. Other Merge Healthcare products include Merge-COM, software development toolkits that help modality vendors and health IT software providers in the development of new imaging applications; Cedara Open Eyes, a development platform; Cedara I-Reach, a web-enabled picture archiving and communication systems solution; Cedara WebAccess, which enables zero client web viewing; and CADstream application, a product that provides CAD post-processing of MRI studies.*

*Merge Healthcare, which was founded in 1987, markets its products and services to OEMs, imaging centers, hospitals, specialty clinics, contract research organizations, health IT, and device and pharmaceutical companies. Merge Healthcare is headquartered in Milwaukee, WI, and has about 400 employees. In 2009, the company had sales of approximately \$67 million.*

*AMICAS, Inc. (AMICAS), incorporated in 1996, provides a range of radiology and medical image and information management solutions. The AMICAS One Suite solutions provide an end-to-end IT solution for imaging centers, ambulatory care facilities, radiology practices, and billing services. Solutions include automation support for workflow, imaging, revenue cycle management, and document management. Complementing the One Suite product family is AMICAS professional services, a set of client-centered professional and consulting services that assist customers with a transition to a digital enterprise. AMICAS, which is headquartered in Boston, MA, has approximately 400 employees. The company had sales of approximately \$89 million in 2009. In April 2009, AMICAS completed the acquisition of Emageon, Inc., a leading provider of technology solutions for hospitals and healthcare networks, for \$39 million.*

*Merge Healthcare and AMICAS announced on March 5, 2010, that they would enter into a definitive merger agreement pursuant to which Merge Healthcare would acquire all of the outstanding shares of AMICAS for \$6.05 per share in cash, or an aggregate of \$248 million. The board of directors of AMICAS unanimously voted to terminate AMICAS's previously announced agreement of December 24, 2009, with an affiliate of private equity firm Thoma Bravo, LLC, and to enter into the Merge Healthcare Acquisition Agreement. Merge Healthcare's \$6.05 per share cash purchase price represented a premium of approximately 13 percent over the \$5.35 per share price contemplated by the prior agreement with*

*Thoma Bravo, LLC. Merge Healthcare obtained \$240 million of debt and equity commitments to finance the transaction, including \$200 million in bridge financing from Morgan Stanley. In accordance with the terms of its previous agreement with Thoma Bravo, AMICAS agreed to pay the affiliate of Thoma Bravo a termination fee of \$8.6 million. One-half of the termination fee will be reimbursed by Merge Healthcare.*

*As a result of the merger, Merge Healthcare and AMICAS anticipate becoming a leading global healthcare IT provider. The companies now have a combined customer base of approximately 1,500 hospitals and 2,200 outpatient sites in the United States alone, and distribution agreements in more than 35 countries. AMICAS is now a wholly owned subsidiary of Merge Healthcare and its stock has ceased trading on the NASDAQ exchange.*

### Transaction Professionals

**Michael W. Ferro, Jr.** is the Chairman of the Board of Merge Healthcare. **Justin C. Dearborn** is the Chief Executive Officer and a Director. **Anna Hajek** is a Managing Partner. **Steven M. Oreskovich** is the Chief Financial Officer, Principal Accounting Officer, and Treasurer. **Julie Pekarek** is the Chief Marketing Officer. **Ann G. Mayberry-French** is Vice President, Secretary, and General Counsel.

**Stephen N. Kahane, MD** is the President, Chief Executive Officer, and Chairman of the Board of AMICAS. **Kevin C. Burns** is Senior Vice President and Chief Financial Officer. **Frank E. Learns, Jr.** is the Senior Vice President for Client Solutions. **Kang Wang** is the Senior Vice President for Research and Chief Technology Officer. **Craig Newfield** is Senior Vice President and General Counsel.

The law firm of **McDermott Will & Emery LLP** served as the legal counsel to Merge Healthcare on the transaction. **Mark A. Harris**, a partner in the firm's Chicago office, headed up the team.

**Mintz, Levin, Cohn, Ferris, Glovsky, and Popeo, P.C.** serves as the corporate and securities counsel to AMICAS and acted as legal counsel to AMICAS on the transaction. **John R. Pomerance**, a senior partner in the firm's Corporate Practice, and **Megan N. Gates**, a partner in the Corporate Practice and Co-Chair of the firm's Securities Practice Group, worked on the transaction.

**Morris, Nichols, Arshat & Tunnell, LLP** served as Delaware counsel to the AMICAS Board of Directors.

**Morgan Stanley & Co., Inc.** served as the financial advisor to Merge Healthcare and as its dealer-manager in connection with the tender offer. **William H. Strong**, Vice Chairman at Morgan Stanley, worked on the deal.

**Raymond James & Associates, Inc.** served as independent financial advisor to the AMICAS board on the transaction. **Riley Sweat**, Managing Director and Co-head of Health Care Investment Banking, led the engagement. **Reed F. Welch**, Managing Director in the firm's Denver office, also worked on the deal.

**Joele Frank, Wilkinson Brimmer Katcher** acted as public relations consultant on the transaction. **Matthew Sherman**, a partner with the firm, and **Andrew Siegel**, Managing Director, led the engagement.

## Med/Loss Ratio, *from page 2*

administrative to medical costs.”

Creating a definition of activities that improve healthcare quality will take time and, until it happens, plans are flying blind. “It’s hard to imagine any list that could ever be complete,” Yood says.

There are a lot of ways that payers formulate payments, says Lisa Han, a partner at Squire Sanders. Bundling, capitation – all have their reasons, some of which is cost control, some of which may be about spreading risk. All of this has to be taken into account, and plans need to be ready to plead their case during the public comment period. “The consequences of not having control of this process means you could end up repaying millions in premiums – you could end up being punished for making more money,” Han says.

Right now, you should be doing internal audits to see what you currently categorize as patient care and what is administration, she says. Remember that the NAIC is heavily weighted to property and casualty and may not have as good an understanding of healthcare. “They may not like some of what integrated delivery systems do with payments in terms of bundling.”

It is up to the healthcare industry to educate the NAIC, NAIU, and even the Department of Health and Human Services (HHS) about what they do and why they do it. “We have to convince them to make adjustments for some cushion, for some reserve, or in a bad year, you could end up going out of business,” Han concludes.

Golden agrees that the repercussions could be huge. “Insurance isn’t about individuals,” he says. “It’s a well-intended part of the law, but the ramifications of trying to treat people equally could be great.”

The point of the new law is to ensure that insurance companies dedicate more money to patient care and quality improvement, and less to giant bonuses, says Maria Currier, Chair of the National Health Care Reform Task Force at Holland & Knight. “The key question is how we define activities that improve health care that can be included as a medical expense,” she says. Through May 15, HHS will take some preliminary comments. After that, it’s all going to be decided by the NAIC, NAIU, and HHS.

You have to be at the table, Golden says. “If you don’t participate, it will be decided for you.” □

## Making the Grade, *from page 1*

To add fuel to physicians’ fire on the topic, a December article in the *Journal of the American Medical Association* by researchers from the Centers for Medicare and Medicaid Services (CMS), found that it’s hard to create a good profiling program because few practices are big enough to provide enough data for each physician on specific measurements. Fully two-thirds of Medicare practices are too small to have enough beneficiaries to “reliably differentiate their practices performance from national quality and cost benchmarks,” the report states. “Only the largest primary care physician practices, which are also the most uncommon, can be expected to have sufficient case loads to measure significant differences in performance.” To do this right, you’re going to have to pool patients from different payers. Doing so would require an element of cooperation and willingness to share financial data that might not be easy to achieve.

The papers are different, says lead author of the *JAMA* article David J. Nyweide, PhD, of the CMS. “There are different methods of profiling and different things to measure,” but regardless, both papers found weaknesses in the programs they studied.

Physicians have long felt that profiling isn’t fair – one physician will say his patients are sicker or she takes more clinic time and less hospital time. This one may specialize in geriatric patients in her

primary care practice while that one is the only one who delivers babies. “There is no right way of doing this,” he says. “My job is to point out the mine fields, and there will be drawbacks no matter what you do. You can only make it as transparent as possible.”

Not that there isn’t a way to accurately measure certain aspects of healthcare at the physician level. You just have to find what’s common to all of them: patient experience measures are one. Still, Nyweide acknowledges that physicians would rather get this information in private – and if you can have the same beneficial impact on patient outcomes or costs, it’s better to choose that way just because it will cause less grief in an organization.

Physicians have to buy into this for it to work. Executives at Blue Shield of California (BSCA) think they have a plan that physicians will support, even if it takes some convincing. They announced the California Physician Performance Initiative Blue Ribbon program last month. It’s an outgrowth of a CMS demonstration program that looked at information on physicians and patients from three different health plans covering thousands of physicians, says Michael-Anne Browne, MD, Medical Director for Quality at BSCA.

Even emphasizing quality measures rather than costs, Browne admitted that physicians aren’t comfortable with the public reporting aspect. Indeed, the California Medical Association was quick to shoot off a letter of complaint about the plan the day it was announced. But Browne thinks that they’ll jump on board once they understand the program.

“We have physicians on our advisory group, and their input has been considered throughout the planning. We made significant changes along the way. One of the issues we addressed was how to attribute a patient to a particular physician.” They fixed that by giving credit for the visit to the physician who saw the patient, as well as the patients’ regular physician, if they were different. They also allow physicians to challenge their data before results are reported on the BSCA website and submit corrections as needed. During the first year when only physicians saw their report cards, only 1 percent of physicians did. The second year, when told that they were being made public, 9 percent did.

The benchmark is relatively low – the top third of physician performers get a Blue Ribbon; the emphasis being on accomplishment rather than on not meeting goals. “We worked with a statistician to develop a buffer and went down far enough to get to 95 percent reliability.” With the buffer built in, roughly half the physicians will get ribbons. Eventually, Browne hopes that the benchmarks can be moved up – to the top quarter of performers.

The goal is to change physician and patient behavior, she says. “Patients don’t seem to use this information to make difficult decisions. But it is an educational tool and helping them think differently about their choices. And it can be enlightening for physicians to look at their own charts to see where they missed patients in certain areas and how to miss fewer.”

Over time, she says they hope to find physicians more engaged – asking for patient lists to ensure they are getting the things done for patients that need to be done, like diabetes tests, mammograms, or vaccinations. Patients who use the website are also being surveyed to see if they find it helpful.

“It’s not about cost for us,” says Browne. “We are looking at this for evidence of when care has been missed to see if we can actually improve our numbers. There is more variation with an episode of care than there is in getting a particular test. We are looking at more discreet and evidence-based data. There is consensus that certain tests should happen. It doesn’t matter if they are overweight or have heart disease, while in terms of cost, it might. The cost of a heart attack is different if you are a smoker or obese or diabetic or all three. But a test is a test. It’s done or not done.” □

# Special Report

## People to Watch in Healthcare Transactions in the Southwest – 2010

Name	Firm	Outstanding Achievement
<b>Don Barbo</b>	Healthcare Valuation Services Mid America Deloitte Finan. Adv. Serv. Dallas, TX dbarbo@deloitte.com	Assisted clients in purchasing primary care and specialty physician practices by performing reimbursement analyses, business valuations, and physician compensation projections. Assisted clients in purchasing general acute care and rural hospitals, ASCs, and imaging centers. Assisted in litigation matters, including buyouts of non-competes and compensation disputes.
<b>Kevyn DeMartino</b>	Transition Capital Partners Dallas, TX kevyn@tcplp.com	As Managing Partner of 15-year old, Dallas-based private equity firm, invests in healthcare entities in the Southwest and Southeast, with a focus on lower middle-market, service-based companies. Previous and current activity includes investments in home health, hospice, behavioral health, and DME.
<b>G. Nicholas Graham</b>	Shattuck Hammond Partners Dallas, TX ngraham@shattuckhammond.com	Healthcare and technology investment banking experience includes recent southwest-based (Dallas) joint venture transaction involving Baylor and U.S. Oncology. Advised on formation of the joint venture (med fusion), as well as the capital raised. Currently has several active transaction engagements, including two in Texas (San Antonio and Dallas).
<b>Michael Hicks, M.D.</b>	AnesthesiaCare/Pinnacle Anesthesia Consultants Dallas, Texas mhicks@pinnaclepartnersmed.com	Has grown company into one of the largest anesthesia care providers in the country. Led the creation and development of Pinnacle's affiliated management company through organic growth and acquisitions, culminating in sale of its management company to AnesthesiaCare, the EMSC anesthesiology management services operation, in December 2009.
<b>Luke James</b>	Encompass Home Health Dallas, TX jljames@ehhi.com	Became VP of Business Development in 2008, expanding work in acquisition process. Has played an active role in the completion of 20 transactions totaling almost \$100M in acquired revenue throughout the states of TX, OK, CO, and NM, including overseeing 7 transactions since assuming expanded role in late 2008.
<b>Greg Koonsman</b>	VMG Health Dallas, Texas gregk@vmghealth.com	Senior Partner and Founder of VMG Health. Since 1995, has provided valuation and transaction advisory services to clients in thousands of hospital, surgery center, HMO, physician organization, and various other healthcare entity transactions. Together with other partners, has led the growth of VMG Health, doubling its size over recent years.
<b>William D. Lautman</b>	Nexus Health Capital New York, NY WDL@nexushealthcap.com	Managing Partner of NY-based investment banking firm with offices in Dallas. Recent transactions in the SW include combined debt recap (financed by Goldman Sachs Specialty Lending Group) and growth capital private equity transaction (Goldman Sachs and Enhanced Equity Fund as investors) for Arizona-based NextCare, and sale of Santé Rehabilitation Group.
<b>Lew N. Little, Jr.</b>	Harden Healthcare Austin, TX www.hardenhealthcare.com	CEO/Co-founder of Harden Healthcare in 2001, which is now one of the largest home health operators in the country. Harden operates and manages 34 senior care facilities through its subsidiary TRISUN Healthcare, provides therapy services (MBS Rehab), long-term care pharmacy services (MBS Pharmacy), and hospice services (Lighthouse Hospice) in Texas.
<b>Peter C. November</b>	LHC Group Lafayette, LA pete.november@lhcgrou.com	Headed LHC's 19 acquisitions last year of home health companies, adding nearly \$75MM in revenues to LHC. Acquisitions included HomeCall, Ochsner Home Health, Feliciana Home Health, Assured Home Health and Hospice, Gulf States Health Service, Three Rivers Comm. Hospital, Methodist Hospital, Northeast Washington Home Health, and others.
<b>Louis E. Robichaux IV</b>	Bridge Associates Dallas, TX lrobichaux@bridgellc.com	Serves as CRO for Renaissance Health Systems and leads Bridge's team serving as RA to this owner/operator of five hospitals in Texas. Served as CRO for Physicians Specialty Hospital and led Bridge team that managed \$363 sale. Served as interim CFO and RA to Healthcare Partners Investments, which successfully completed out-of-court turnaround and recap.

# Worth Reading

## Hospital Turnarounds – Lessons in Leadership

Editors: Terence F. Moore and Earl A. Simendinger

Publisher: Beard Books

Softcover: 244 pages

Price: \$34.95

Review by Henry Berry

*Hospital Turnarounds – Lessons in Leadership* is a compilation of twelve essays on the many approaches that have been taken to resuscitate hospitals in distressed situations. Most of the essayists are CEOs or presidents of hospitals or healthcare organizations, and their stories are all different and compelling in their own way. The hospitals differ in their size, marketplace, facilities, and services offered. The causes of their distress vary and the strategies that were used to overcome them are wide-ranging. All-in-all, it makes for an engaging collection of success stories.

The authors have extensive experience in the healthcare system, and nearly all have held top leadership posts in several public and private hospitals. Most importantly, all have been involved in successful turnarounds at some time in their careers. Two of the authors are from the field of marketing, which can play a significant role in hospital turnarounds.

The number of troubled hospitals rises and falls over time, depending on many factors, including the state of the U.S. economy. There are always some hospitals in a distressed situation or teetering close to it. In spite of the fact that healthcare is a basic need in U.S. society, hospitals are constantly vulnerable to financial problems because of competition, changing medical technology, new approaches to healthcare from improved drugs and public awareness, and medical malpractice lawsuits. Any or all of these factors can be financially crippling and, even if the financial impact is minimized, a hospital's reputation can be damaged. Like any other business organization, hospitals can also run into difficulty because of poor management or labor problems.

The first and last chapters, "Introduction" and "Turnarounds: An Epilogue," respectively, are written by the co-editors. The balance of the chapters contain first-hand accounts of hospital turnarounds, with the authors asked by the co-editors to "document the role of the various publics." The authors do this, offering their assessment of the role of the board of directors, medical staff, management team, volunteers, and other relevant "publics" in the respective turnarounds. A common thread in this book is that the import and activities of these publics were different in every turnaround. Each turnaround had to address its own grievous, overriding problem or set of problems. Each turnaround had its own cast of characters who brought different backgrounds and skills to the turnaround. As a result, each path taken to overcoming the distressed situation was different.

No matter what the cause or causes of a hospital's distressed situation, in nearly every case the problems were first realized

when a financial problem became apparent. Thus, turnarounds are inevitably focused on improving a hospital's financial situation. As one of the authors notes, "A turnaround is most often the result of increased revenues and decreased expenses." The approach taken by some of the authors was to focus on "[increasing] revenues to improve the operating margins of their organizations." Many other turnarounds were accomplished by focusing on reducing expenses. Invariably, however, a combination of both was needed and working toward these paired objectives required a new strategic thinking and the development of operational capabilities that prepared the hospital for long-term survival in continually changing market conditions. One author's prescription for success was, "Upward communication, fluidity of organizational structure, a reduction of unnecessary bureaucratic rules and policies, and ambitious yet realistic goals and objectives." These practices are present in healthy companies and usually missing in distressed companies. Implementation of these business practices is essential for a hospital to return to a favorable financial footing.

Another author addressed "organizational burnout," which must be corrected if a hospital is to survive. Burnout is evident when "the sum of an organization's actual output is decreasing over time when compared with its potential output." The challenge facing hospital executives and turnaround specialists is to reduce – and ideally, eliminate – the gap between actual and potential output. The smaller the gap, the more efficient, productive, and healthy the organization.

These are just a few of the observations and lessons provided in this collection of essays. Through engaging first-person accounts of rescue stories, the reader learns what a turnaround is all about, how to diagnose a distressed situation, and how to formulate a strategy that implements specific corrective actions.

*Terence F. Moore has been involved in the Michigan hospital system as President and CEO of Mid-Michigan Health, Board Member of the Michigan Hospital Association, and Chair of the East Michigan Hospital Association. He is also a fellow of the American College of Healthcare Executives. Earl A. Simendinger is a professor of management at the College of Business at the University of Tampa who for 20 years was a hospital administrator. Also a fellow in the American College of Healthcare Executives, he has written many books and articles on management and organizational development.*

# Special Report

## Outstanding Healthcare Fraud & Compliance Lawyers – 2010

Lawyer	Firm	Outstanding Achievements
<b>Eric M. Baim</b>	Hogan & Hartson Washington, DC Tel.: (202) 637-5537 embaim@hhlaw.com	Counsel for leading pharmaceutical/medical device companies. Assisted various industry associations with drafting legislative language related to federal physician payment transparency provisions and self-referral disclosure protocol which was advocated for, and ultimately incorporated into, health reform overhaul signed into law in March 2010.
<b>Anthea R. Daniels</b>	Calfee, Halter & Griswold Cleveland, OH Tel.: (216) 622-8391 adaniels@calfee.com	Negotiated hospital outpatient provider settlement and corporate integrity agreement where settlement was minimal after years of subpoenas and inquiries from the FBI, HHS, and OIG. Assisted hospitals and health systems with excluded employee self-disclosure and responding to subpoenas for payment issues, and successfully negotiated away interest and penalties.
<b>Lisa Estrada</b>	Arent Fox Washington, DC Tel.: (202) 857-6000 estrada.lisa@arentfox.com	Represented hospice organization facing multi-faceted fraud and abuse challenge. Innovative response in newly exposed area of fraud defense, requiring extensive education of U.S. Attorney's office in factual realities of end-of life-care. Worked with board and outside financing organizations on response to whistleblower law suit with govt. investigation.
<b>Hope Foster</b>	Mintz Levin Washington, DC Tel.: (202) 661-8758 HSFoster@mintz.com	Assisted Quest Diagnostics and Nichols Institute Diagnostics in resolving federal criminal and civil cases arising from a qui tam complaint challenging aspects of manufacture and distribution of in vitro diagnostic products. Assisted Teva Pharmaceuticals to resolve qui tam case against then indirect subsidiaries alleging violation of Anti Kickback Act and FCA.
<b>Mark S. Hardiman</b>	Hooper Lundy & Bookman Los Angeles, CA Tel. (310) 551-8197 mhardiman@health-law.com	Represented various physicians charged with issuing invalid prescriptions over the Internet, allegedly prescribing unnecessary controlled substances, and criminally charged with submission of false claims to the Medicare program. Represented hospital in voluntary self-disclosure to OIG of possible civil false claims relating to Medicare cost reporting.
<b>Christopher G. Janney</b>	Sonnenschein Nath & Rosenthal Washington, DC Tel.: (202) 408-9151 cjanney@sonnenschein.com	Represented large non-profit acute care hospital in multi-year defense of \$100 million civil FCA case in which government ultimately declined to intervene. Representing more than 15 hospitals in national "short-stay" claim investigations, and a variety of healthcare organizations in large and complex civil FCA cases and government and internal investigations and audits.
<b>David E. Matyas</b>	EpsteinBeckerGreen Washington, DC Tel. (202) 861-1833 dmatyas@ebglaw.com	Working with several clients on investigations by applicable U.S. attorney's office and DOJ targeting certain providers across the country. Counsels clients on various fraud and abuse matters. Recently retained by a private equity-backed bio company to address certain potential fraud and regulatory issues that potential purchaser identified during due diligence process.
<b>Daniel Meron</b>	Latham & Watkins Washington, DC Tel.: (202) 637-2248 daniel.meron@lw.com	Represents Endoscopic Technologies in recently terminated investigation of off-label promotions, false claims submissions to Medicare, and violations of anti-kickback statute. Represents Northstar Healthcare in dispute with large private payor and fraud litigation against seller of ASC. Selected by Eli Lilly to handle healthcare litigation and investigation work.
<b>Paul W. Shaw</b>	K&L Gates Boston, MA Tel.: (617) 261-3111 paul.shaw@klgates.com	Successfully represented national pharmaceutical service company in DOJ investigations, resulting in global civil resolution of five qui tam actions. Obtained DOJ declination to intervene in False Claims Act qui tam case against an academic medical center. Obtained dismissal of lawsuit brought against neurologist for promoting off-label use of a major drug.
<b>Howard Young</b>	Morgan, Lewis & Bockius Washington, DC Tel.: (202) 739-5461 hyoung@morganlewis.com	Recently counseled hospitals on DOJ FCA kyphoplasty investigations, physician relationship Stark Law investigations, and medical necessity and billing self-disclosures. Counsel to various hospice and long-term care providers on transactions, OIG subpoena responses, and CIA and other compliance matters.

# In Focus

## Health Management Associates

Founded in 1985, Health Management Associates (HMA) is a Lansing, MI-based consultancy with expertise in the public arena of healthcare. Local, state, and federal governments, as well as national foundations and health systems hire Health Management Associates to provide expertise in both public and private sectors.

The company has 10 offices along with the Michigan headquarters: Atlanta, GA; Austin, TX; Boston, MA; Columbus, OH; Indianapolis, IN; New York City, NY; Sacramento, CA; Tallahassee, FL, and Washington, DC.

The nine managing principles and another five dozen professionals nearly all have experience in state or federal government health programs, and include 10 former state Medicaid directors, three former SCHIP directors, state budget officials, and advisors to governors and other elected officials.

Along with government agencies, HMA works with employers and other health coverage purchasers, and a variety of public and private organizations. Among the consultancy's clients are: CMS, Indian Health Centers, the Kaiser Commission on Medicaid and the Uninsured, the National Conference of State Legislatures, 30 states, and the territory of Guam. The company is a recognized expert in Medicare and Medicaid, providers who participate or have a stake in the programs, and the foundations that evaluate the outcomes of these organizations. It offers a variety of services, including regulatory compliance services, data research and analysis, finance and reimbursement strategies, healthcare policy, market and regulatory services, health system development and restructuring, industry analysis, payment forecasting, pharmacy services, and managed care and program and market development.

The most recent addition to the organization is HMA Investment Services. In a press release on the new offering, HMA notes that with the extension of Medicaid eligibility to some 15 million people, capital will flow to organizations that can deliver "high-quality, cost-effective services to state partners. HMA Investment Services's goal is to assist investment professionals in evaluating opportunities amid the changing healthcare landscape."

Although the company has had only a single webinar, Chief Executive Officer Marilyn Evert says there will be more in the future. For now, HMA offer a variety of publications to complement its consulting services. Among the publications released this year are several on Medicaid enrollment, CHIP, and member retention. The most recent report, released on April 30, looks at California's hospital system. HMA also started publishing a quarterly newsletter in April.

Evert believes that HMA is unique in the healthcare consulting market. "I don't know of another organization that focuses as tightly as we do on the publicly financed healthcare programs for the low income and uninsured," says Evert. "There are other organizations that do some of that, but we think that we have a unique capability to understand and serve that comes from having so many people that come from that arena. We do work for foundations, for big safety

net hospital systems, for private sector clients. Virtually everything we do in some way relates to publicly financed healthcare. And we also have national scope, while others are limited to a particular geographic area."

Evert started with the firm in 1999. She is a former state official with over 20 years in health policy, program development, government relations, and marketing. At HMA, she helps clients with program design and implementation and works with state agencies, private organizations, and foundations. She has also been responsible for the day-to-day operation of the firm. Before joining the organization, she worked with the Florida Agency for Health Care Administration.

Along with Evert, HMA is led by Founder and President **Jay Rosen**. Responsible for overall management, Rosen has worked in the healthcare industry for over 30 years. For HMA, Rosen's principle activities involve helping healthcare organizations gain insight into healthcare trends and translate that into effective patient care and business strategies. He also directs major projects for public and private healthcare organizations.

As of April 1, HMA has a new position, Vice President and Chief Operating Officer, held by Kelly Johnson, who is HMA's former managing principle. In her previous position, Johnson performed market and feasibility analyses for new business opportunities and prepared requests for proposals and HMO licenses. She has been with the firm for about 15 years and will take over day-to-day operations from Evert.

**Bruce Gould** is Chief Financial Officer for HMA. Gould has been with the firm since 2007. Before that, he spent 13 years at a large non-profit health system, the last nine of them as controller. He spent five years as the controller for a national real estate magazine, and another five at a public accounting firm.

The rest of the management team of the privately held company is made up of the nine managing principles who meet regularly, either in person or virtually to handle firm business.

For more information on Health Management Associates, see [www.healthmanagement.com](http://www.healthmanagement.com). □

## Ripple Effect, *from page 2*

organizations, Van Denmark says.

Still, health plans are protecting themselves by requiring patients to sign waivers and releases, acknowledging they understand the risks associated with overseas travel and surgery. Foreign providers and facilitators also have to sign documents recognizing the roles each plays in the patients' treatment plan, adds Kevin Ryan, Van Denmark's partner at EpsteinBeckerGreen.

The insurance industry "will remain unsettled over the next couple of years as it acclimates itself to health care reform," Stackpole says. Until then, uninsured individuals and self-insured providers "may not be the best targets for medical tourism marketing."

Within 14 months to 18 months, the average American consumer "will wake up to the fact that health reform legislation will cost them a lot more," he adds. "The underinsured may become the best overseas market for non-urgent procedures if [they] think the government would cover some or all of these procedures." □