

Healthcare Equipment Finance Check Up

Opportunity persists, despite regulatory pressures.

By Alan N. Frankel

Turbulent times are ahead for the healthcare equipment leasing and finance industry if Congress and the current administration do not address skyrocketing healthcare costs and the impending failure of the Medicare program within the next 18 to 20 years.

Healthcare providers across the board are facing draconian measures with significant potential to threaten their financial viability. It started with the Deficit Reduction Act of 2005 (DRA), which includes numerous provisions affecting physician Medicare payment policies. DRA is estimated to slow the pace of both Medicare and Medicaid spending (2006-2011 savings of \$6 billion and \$5 billion, respectively). The proposed Medicare physician fee schedule (PFS) regulations released on July 2, 2007 call for a nearly 10 percent decrease in Medicare physician fee schedule payments.



Hospitals, long-term care facilities, ambulatory surgical facilities (ASCs), diagnostic testing facilities—all will be affected. Consider the effect on physicians, most of whom are small business owners. If their income cannot cover the cost of providing care, then adjustments must be made, whether in overhead (including salaries, equipment, and technology) or service delivery. Quite possibly, Medicare/Medicaid beneficiaries could be the ultimate victims because fewer physicians will be willing to treat its 40 million enrollees.

There's more to the cost equation than reimbursement reductions. Re-evaluating Stark Law provisions, the Centers for Medicare and Medicaid Services (CMS) proposes to close perceived loopholes, such as block leasing and services furnished "under arrangements."

Yet there is opportunity for cost reduction through the application of technology, which opens new possibilities for the equipment finance industry. The Bush administration is aggressively pursuing the development of a health information technology network (HIT) to provide electronic billing, electronic patient records, patient outcomes reporting, electronic physician order entry for medications, and patient records portability. Still, the potential for the equipment finance industry (and for individual companies) must always be evaluated in light of healthcare IT market complexity. Regulatory and technological dynamics are perhaps the most obvious, but distribution channel and licensing challenges can have significant effects on program structures and viability.

Who and What is Affected

Diagnostic imaging providers—

Reimbursement cuts implemented in 2007 for procedures performed in a physician's office or independent diagnostic testing facilities (IDTFs) threaten the \$75 billion–\$100B radiology and imaging marketplace. The potential to affect the leasing and finance industry is significant. Diagnostic imaging currently has the highest lease penetration rates by equipment type (estimated 35-50 percent vs. the industry average of fewer than 15 percent for other modalities) because of several factors, including higher patient demand for non-invasive tests and the growing practice of defensive medicine. (Yet it is interesting to note that the number of MRI and CT machines in the U.S. on a per capita basis is less than in most other industrialized nations.) DRA provided for two changes that many providers believe are draconian: A reduction in reimbursement for the second and subsequent similar images of contiguous body parts in the same session, and caps on the technical component of imaging services provided in the physician's office or IDTF. These reimbursements exceed those payable under the Medicare Hospital Outpatient Pro-

spective Payment System (HOPPS). These caps apply to magnetic resonance imaging, CT, ultrasound, nuclear medicine (including PET), bone densitometry and fluoroscopy. Diagnostic and screening mammography is exempt.

Ambulatory surgical centers—

On July 16, 2007, CMS posted its final ruling changing Medicare's ambulatory surgery center (ASC) payment system, revising the ASC payment system using the HOPPS relative payment weights as a guide. The guidelines are intended to set rates at approximately 67 percent of inpatient rates, but for most procedures may be closer to 62 percent.

From a high-level policy perspective, the new ASC payment methodology includes many important improvements, but in reality it's somewhat mixed. New definitions permit more "covered surgical procedures" to be furnished in the ASC, but the "office-based" cap limits the ability of many ASCs to furnish these services. For example, those ASCs specializing in orthopedic procedures will benefit substantially, but ASCs specializing in gastroenterology and pain management will likely see dramatic (more than 20 percent) revenue decreases. Consider the current and new payments for several high-volume ASC procedures:

Descriptor	2007 ASC Payment	2008 Fully Implemented ASC Payment
Remove cataract	\$973	\$1,005
Diagnostic colonoscopy	\$446	\$373
Cystoscopy	\$333	\$276
Carpal tunnel surgery	\$446	\$759

Physicians—It would be difficult, if not impossible, for any small business to absorb continued income loss in the face of escalating expenses. Thus, many physicians will have to scramble to make adjustments because of DRA, whether in salaries, equipment and technology investments, or range of services provided.

An American Medical Association survey found 32 percent of physicians would accept fewer new Medicare patients under the proposed payment cuts, and 28 percent said they would stop accepting new patients on the federal insurance plan altogether. According to a survey conducted by the American Medical Group Association, a majority would continue to treat Medicare patients, but would limit new physician hires and limit upgrades to electronic medical records.

Sadly, many providers working in “underserved” locations will really feel the blow. This year, a Medicare provision expires that ensures physicians in all geographic areas receive no lower than a specified amount for treatment. Without that provision, rural physicians tend to receive much lower Medicare payments than those practicing in cities.

Implications and Complications

The simple equation: how might a 10 percent (in many cases) “pay cut” affect a provider’s financial



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There is opportunity for cost reduction through the application of technology, which opens new possibilities for the equipment finance industry.



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Coming Soon

What Goes Into the Decision to Finance Equipment?

The Equipment Leasing & Finance Foundation will release its newest study providing you a better understanding of how companies manage their equipment purchases or acquisitions. A few of the areas explored through the study include:

- A look at the characteristics of equipment acquisition by small and large companies and by equipment volume.
- The acquisition characteristics based on equipment type and end user.
- An analysis of various types of financing and their use as it relates to equipment acquisition.
- Predictive models to enhance your strategic growth decisions.
- And so much more.

Propensity of Businesses to Finance Capital Equipment Purchases

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Donors receive the study free of charge. Non-Donors: \$200

viability, which in turn affects its ability to invest in, and continue to pay for equipment? Remember, their equipment spend must compete with salaries, overhead, and already crushing malpractice insurance premiums.

Going forward, finance companies should consider what specialties will be helped or hurt by reimbursement cuts. This is especially important for small ticket lessors. Most small ticket leases are done on an application only basis. Therefore, consider what steps you must take to modify credit criteria, perhaps by raising FICO scores.

Next, equipment financiers must consider how DRA will affect transactions already on the books. How many will still be viable? For troubled transactions: how can you “stretch out the deal?” What expertise (legal, healthcare industry, equipment/technology) can you marshal to prevent default? Moreover, if default does occur, what is your recourse?

Further Complications: Stark Law Provisions

CMS is also using this PFS rulemaking as a vehicle to revise the ever-expanding Stark Law regulations.

“Per Click” Leases—Stark law regulations currently permit per click payments for personal services, as well as space and equipment leases, so long as the payment per unit is at fair market value and does not change during the term of the arrangement. Accordingly, a physician

may lease a piece of equipment to a hospital on a per click basis, even if the physician refers patients to the hospital for services using the equipment. CMS has now determined that “such arrangements are inherently susceptible to abuse,” and proposed to narrow the exceptions for space and equipment leases (but not for services) so that per click payments would not be permitted “to the extent that such charges reflect services provided to patients referred by the lessor to the lessee.”

Block Leasing—CMS also proposes prohibiting IDTFs from sharing space, equipment, or staff, or from subleasing its operations to another individual or organization, “to better enable CMS to confirm that an IDTF is operating in compliance with the Medicare conditions of participation.” Why? These “shared arrangements” raise concerns under the physician self-referral prohibition and the federal anti-kickback statute.

Services furnished “under arrangements”—Here, CMS expresses concerns about possible inappropriate financial incentives emanating from “under arrangements” transactions between physician-owned “Intermediary Entities” and hospitals, ASCs and IDTFs. For example, mobile or fixed site PET scan, nuclear stress testing and radiation therapy services arrangements between a hospital and an independent, physician-owned provider of these services to the hospital’s patients would have to be terminated or the associated Medicare billing stopped unless the referring physicians are divested.

Opportunity HITs

In April 2004, President Bush created the post of National Health Information Technology Coordinator within the Department of Health and Human Services (HHS). The mandate to create such a HIT infrastructure led to a 10-year plan by HHS, introduced in 2004. Once this is in place, there will be great cost savings through the elimination of inefficiencies and medical errors. Another benefit will be the wider availability of medical outcomes

reporting, permitting patients to become smarter consumers.

According to a September/October 2005 article in *Health Affairs*, when a law finally does go into effect the cumulative costs for adoption are estimated at \$98 billion for hospitals and \$17.2 billion for physicians, providing finance companies with an excellent opportunity. The average yearly costs for hospitals and doctors over a 15-year period are \$6.5 and \$1.1 billion, respectively.

Farsighted entrepreneurs, not con-

The advertisement features a blue diagonal banner in the top right corner with the text "Coming Soon". The main text is centered and reads: "Looking for the next growth market? Think Alternative Energy!". Below this, it states: "The Equipment Leasing & Finance Foundation will release its newest study examining the opportunities and challenges of financing alternative energy equipment. This study examines the current state, the business impact and the future projections for the alternative energy financing sector." The title of the study is "Alternative Energy Financing – Where are the Opportunities?". At the bottom, it says: "Published by the Equipment Leasing & Finance Foundation Available at www.LeaseFoundation.org or 202-238-3400" and "Donors receive the study free of charge, Non- Donors: \$200".

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Enhancing Corporate Capabilities through Outsourcing

The Equipment Leasing & Finance Foundation has commissioned a white paper on how companies in the equipment leasing and finance business can and do enhance their capabilities and performance by outsourcing business processes.

Determine what processes, if any, could be enhanced through outsourcing. Learn what business processes should stay in-house, and so much more!

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tent to wait for Congress, are ready to reap the benefits of higher reimbursement rates and better outcomes. Consider the recent growth of the Regional Health Information Organization (RHIO). The goal of a RHIO (whether a payer-sponsored or employer-sponsored program) is to increase efficiency and improve safety for healthcare processes and patients. Shared Health, a payer-sponsored RHIO in Tennessee, provides access to more than one million clinical documentation and community health records by more than 2,500 users on 500 sites.

The federal impetus is spurring innovation and new development. This means that opportunities for equipment financiers—whether small-ticket lessors, vendor-based companies, operating lease organizations and big-ticket players—will be significant, as its implementation will amount to the largest segment buy in healthcare history, from small physicians office programs to total multi-facility information systems. The latter, with costs running in the millions of dollars, may predominantly be software transactions. In between are many departmental and procedure-specific systems that may have a greater or lesser impact on cost savings and patient outcomes and greater or lesser risks as leaseable assets. These include: PACS and RIS systems for the capturing and transmission of digital images; clinical laboratory systems; pharmacy systems (ranging from automated dispensing carts to pick-and-place equipment to electronic prescription writing and filling systems); cardiology information systems; electronic

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billing systems; financial management systems; even bio-terrorism prevention.

Nevertheless, there will be risks that could undo finance companies heedless to the market’s complexity or careless in their due diligence. These risks could include financing large amounts of software-only transactions, including proprietary systems.

What if your client is financing a proprietary program from an entrepreneur writing code out of his garage? How do you protect your investment if that developer goes out of business? Do you have the risk appetite for that type of “unsecured financing?” Other options include financing through hosted ASP models, or financiers generating revenue based on percentage of savings (although with the NorVergence controversy still quite real for many, this model may take some time to gain more widespread acceptance.)

Beyond HIT: Other Opportunities

Joint ventures with equipment manufacturers. These may provide some protection for the lessor while still permitting sale treatment to the manufacturer.

FMV leases to hospitals. Hospital administrators are now more routinely compensated on a return on assets basis, leading to a greater opportunity for off-balance sheet leasing.

Per procedure or per-click programs, which may be

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If so, this study is a **MUST READ**.

This new study, **The Impact of Going Paperless**, focuses on the opportunities and challenges of conducting business within a paperless environment.

- Explore the current state of automation in the equipment finance industry.
- Collect intelligence on the legal framework and regulations impacting electronic transactions.
- Understand relevant important security issues.
- Learn about the reactions of rating agencies and governmental entities.
- Develop greater knowledge on the future of electronic contracts and its impact on all aspects of the equipment finance business.

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Surviving the Storm

Complex changes in regulation and reimbursement characterize today's health care environment. Therefore, it is essential for healthcare equipment and IT financiers to prudently position their products and services in step with proposed reimbursement changes.

- Consider what specialties in your target markets will be helped or hurt by reimbursement cuts, and take the appropriate measures to modify credit criteria (for example, by raising FICO scores in the small ticket arena).
- Evaluate how regulatory changes could affect lease transactions already on the books. For troubled transactions, what expertise (legal, healthcare industry, equipment/technology) can you marshal to “stretch out the deal” or prevent default?
- Thinking about entry into the healthcare space—or expansion within new market segments? Simply being as good as the incumbents won't do—differentiation is critical!
- Explore new possibilities, such as FMV leases to hospitals or refinancing existing transactions.
- The HIT market presents tremendous potential, but has inherent challenges: the healthcare industry's regulatory and technological dynamics along with distribution channel and licensing issues. For those lessors who have been lax in their due diligence, the downside is great.
- Remember the breadth of healthcare equipment modalities is wider and the change in technologies is more rapid than in many other markets—necessitating strong asset management capabilities.
- Finally: Stay up to date with all new regulations and make sure you have a clear understanding of their implications on your business.

treated as operating expenses.

Re-financing of existing transactions to help spread the cost over a longer period to account for reimbursement reductions.

Leasing of used equipment. Keep in mind, however, that most healthcare equipment is covered by FDA regulations. A third party lessor would most likely require refurbishing and remarketing assistance from

the manufacturer, as well as having access to domestic and international used equipment purveyors.

International leasing. Some of the same drivers behind the HIT system in the U.S. are present in other countries. Similar measures are underway in the U.K. to automate clinical processes and digitize medical records.

Non-traditional settings. A new

study, “Retail Clinics: Primary Care Evolution or Revolution?” released in April 2007 by healthcare researchers Market Strategies, Inc., Livonia, Michigan, documents consumer acceptance of—and in some cases reliance on—“mini clinics” for the delivery of primary care. What's most interesting is the clinics' appeal to two polar opposite demographic groups: upper-income households who see these sites as “supplements” to their primary care physician for quick treatment of minor illnesses or for after-hours treatment; and uninsured households who see these clinics as offering affordable health care.

Shortly after the study's release, Wal-Mart announced plans to opening mini-clinics in as many as 400 U.S. stores in the next two to three years and possibly 2,000 in the next five to seven years. CVS and Walgreens announced similar expansion but on smaller scales. Could this be a new opportunity for the small ticket market, in that there may be fewer Medicare repercussions?

Getting In

Why consider entry into the healthcare space—or expansion within new market segments? It's a dynamic marketplace, subject to shifts due to governmental regulation. Medicare/Medicaid financial issues loom. Look at the small ticket market as an example (and a worthy blueprint). Simply to earn a spot at the table, you must have the appropriate “givens:” application only credit processing of a minimum of \$200,000-\$250,000;

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maximum 1-2 hour credit turnaround time; a simple e-mailable one-page lease document; fax funding capability for up to a reasonable dollar amount; and for that 360-degree view, a front-end system with real-time deal tracking capabilities and a back end system with robust portfolio slice and dice capabilities.

These are minimum requirements offered by tenured players with existing, satisfactory relationships. Simply being as good as the incumbents will not win any business. Finance companies must ruthlessly assess their corporate culture and capabilities to determine how to distinguish themselves—whether through program, service, or segment enhancements—from competitors.

The success mindset cannot stop at origination! Do you have the

people and systems to execute and sustain this business successfully over the long term? The breadth of healthcare equipment modalities is wider and the change in technologies is more rapid than in many other markets. This requires a strong asset management capability on both the residual setting and recovery ends. An increase in FMV leases (as in the hospital environment) requires a strong knowledge of residual setting and access to the used market (whether domestic or international). Most healthcare equipment is covered by FDA regulations and a third party lessor would be hard-pressed to sell equipment directly to an end user.

Just the Beginning

The U.S. still spends an increasing

proportion of its Gross Domestic Product (GDP) on healthcare—much more than any other industrialized nation. In fact, estimates point toward a future where an untenable 25 percent of our GDP will be required to support our healthcare infrastructure. Our per capita healthcare costs are more than 250 percent higher than in other countries.

Accountability for outcome will only intensify, meaning that providers and the technologies they utilize will be viewed under a more critical lens. Yet healthcare equipment financiers can weather the storm, and even prosper by capitalizing on opportunity. ■

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