THE NEWSLETTER FROM THE BDO HEALTHCARE PRACTICE

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HOW WILL HEALTHCARE REFORM IMPACT INVESTMENT IN THE HEALTHCARE INDUSTRY?

By Steven Shill, Healthcare partner and practice leader

The highly anticipated Supreme Court ruling on the constitutionality of The Patient Protection and Affordable Care Act, passed into law in 2010, has again spurred much debate regarding the overall impact these laws will have on business – and on firms investing in the healthcare industry, in particular.

In a recent survey performed by the Financial Executives Research Foundation, senior financial executives were asked about the impact of healthcare reform on private equity transactions over the next 12 to 18 months: 58 percent of respondents indicated that they expected little or no impact, and another 28 percent said there may be a slight decrease in activity. When looking at the first half of 2012, their predictions seem to be accurate. Deal activity has decreased only slightly in 2012 when compared to the first six months of 2011.

In the healthcare industry, however, there has been a more pronounced change. In the first half of 2012, private equity firms executed only 20 healthcare transactions, according to Dealogic, for a total of $997 million. That's compared to 40 transactions during the first half of 2011, which amounted to nearly $4.4 billion.

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HEALTHCARE REFORM IMPACT

The inherent uncertainty surrounding the pending Supreme Court ruling likely drove much of this slowdown, but the decision itself may not lead to an uptick in deal activity. The upcoming presidential election will undoubtedly deliver a second dose of uncertainty and with it, continued reluctance to invest in healthcare.

Nonetheless, healthcare reform does create new dynamics within the industry that may lead to additional investment opportunities for private equity funds:

- One of the primary objectives of healthcare reform is to create a more cost-effective, efficient delivery of healthcare services. As a result, companies that help drive down the costs of healthcare are likely to prosper and attract the attention of investors in the post-reform environment. Examples of these types of companies may include organizations that provide high-tech solutions to lowering the risk of re-admissions in hospitals, enhance electronic medical records systems or create solutions that will administer state healthcare insurance exchanges. The iterations are endless.

- The need for cost reductions will also likely increase the tempo of M&A activity among healthcare providers, including the establishment of integrated delivery systems and accountable care organizations (ACOs). These organizations will require complex, high-tech solutions that facilitate the integration of the various businesses. As physicians leave private practice and join these larger organizations some of the decisions they make regarding drugs prescribed and even medical devices used could change and accordingly, direct investment toward the winners and away from losers.

- Other segments within the healthcare industry are likely to experience consolidation, as well. The increased regulation of rates and margins at health insurers is expected to lead to increased M&A activity. As only a limited number of formularies emerge from consolidation within the health insurance industry, pharmaceutical and life sciences companies will find their products becoming more standardized. This could drive investment firms to different parts of the pharmaceutical and life science sector.

- It will be increasingly important for providers to drive higher revenues in the new healthcare environment, and hospital reimbursements will be directly tied to patient satisfaction. Therefore, the impact of penalties due to re-admission rates and patient satisfaction will become more significant. Trends such as translation services that help medical practitioners communicate with non-English speaking patients are emerging, with high-tech solutions that require bandwidth, recruitment of foreign language-speaking medical personnel that and a significant computer hardware investment to provide these services. Firms will be eying these trends for emerging investment opportunities.

- The myriad of rules and regulations may prove too much for some investors, who will begin looking farther afield to diversify their healthcare investment portfolios. As a result, interest from U.S. investment firms in healthcare companies in emerging economies such as China and India will likely continue to gain momentum.

These examples present a sampling of the magnitude of opportunities that healthcare reform has presented. Although the general consensus is that healthcare reform may not result in a significant change in investments over the longer term, the healthcare reform law does provide a paradigm shift in investment – and the opportunities that investment firms entertain will undoubtedly change, as a result.

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THE CONTINUAL CHANGING REVENUE CYCLE ENVIRONMENT

By: Lynn Marie Pepper, CPAM, Revenue Cycle Services Consultant, The Rybar Group

IN THE HEALTHCARE INDUSTRY TODAY, REVENUE CYCLE LEADERS EXPECT CONTINUAL CHANGE.

The many complexities of healthcare reform, varied interpretations and projections, and planning for the future may not be as much of a science as it is an art. For example, we know that insurance exchanges are developing in every state and that there are, thus far, 88 accountable care organizations (ACOs) nationwide. Original *Congressional Budget Office* (CBO) estimates were that 33 million people were expected to gain coverage under the Affordable Care Act (ACA), but 3 million fewer are now predicted to get insurance (Pear, 2012). In a different report in the Aug. 7, 2012, *Wall Street Journal*, the estimates may be 25 million (Radnofsky, 2012). It is clear: change is coming. What should we do now?

Now is the time to overhaul the revenue cycle. With bundled payments and lower reimbursement inevitable, this calls for careful scrutiny of the entire cash flow pipeline. Are most claims resolved and paid within 60 days? Have you completed a root analysis of the causes of delayed payments? In addition, staff competency level testing and re-testing, financial clearance, point-of-service collections, training and incentive programs and patient self-service technologies, such as registration kiosks and web portals, may need to be implemented as well. Our patients expect we will be leading with fair policies to them and that we are also on the cutting edge of technology and meeting their healthcare needs. Serious times calls for serious measures.

Effective Aug. 27, 2012, the Centers for Medicare & Medicaid Services (CMS) announced that the delayed Prepayment Review Demonstration, originally scheduled for January 2012, will begin. This will be a three-year demonstration project where medical records for selected claims will be reviewed *prior* to payment to check medical necessity. Providers need to pay close attention to their Medicare DDE claim status location reports to monitor claim volume and dollars being held. When you consider the impact other demonstrations have had on hospitals and physicians, this is daunting and we need to pay attention to it since it will surely shape claim processing in the future.

The details of the program have now been defined. It will include a review of MS-DRG 312 Syncope & Collapse. For now, limits on prepayment and post-payment reviews won't typically exceed current post-payment ADR limits. It has yet to be determined, but the demonstration will expand to include seven additional MS-DRGs for transient ischemia, hemorrhage and diabetes. As with other medical-necessity audits though, the outcome will be based on the reviewer's clinical judgment about whether an item or service, including site of care, was eligible for Medicare coverage and was medically reasonable and necessary. The Medicare Recovery Audit Contractor (RAC) will review certain types of claims that historically result in high rates of improper payments. We recommend you follow best practices by establishing a mechanism to track these denials, perform your own independent review/establish your own prepayment review process within your facility, and execute any appeal rights in a timely manner.

The RAC reviews will focus on seven states with high populations of fraud- and error-

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CHANGING REVENUE CYCLE

prone providers (Florida, California, Michigan, Texas, New York, Louisiana and Illinois) and four states with high claim volumes of short inpatient hospital stays (Pennsylvania, Ohio, North Carolina and Missouri). According to CMS, the demonstration will help lower the error rate by preventing improper payments, rather than the traditional methods of looking for improper payments after they occur. Stay tuned.

In addition, effective Aug. 1, 2012, the Medicare fee-for-service (FFS) program automatically converted the ERA (electronic remit advice) also known as the 835 to the X12 Version 5010 format for those providers who had not yet converted from the 4010A1. If the computer software you use to open/ translate the ERA X12 Version 5010 format was not ready for this conversion, you may not be able to open and read the ERA to review payments, adjustments and denials, as well as post payments to patient accounts. Providers need to monitor their ERA files closely to ensure transactions posted correctly to avoid rework and lost payments due to incorrect postings.

Last, but not least, hospitals continue to struggle with the three-day payment rule evolution. Effective with dates of service *on or after July 1, 2012,* ***any non-diagnostic service that is clinically related to the reason for the inpatient admission, regardless of whether the inpatient and outpatient diagnoses are the same, is subject to the three-day payment window,*** As a result, hospitals are required to bundle the technical component of all outpatient diagnostic services and related non-diagnostic services with the inpatient claim when services are provided to a Medicare beneficiary in the three days preceding an inpatient hospital admission.

Under a three-day payment window policy implemented in 1998, hospitals and entities that hospitals wholly own or operate are required to include the technical portion of all outpatient diagnostic services on the inpatient hospital claim. Section 102 of the *Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010* retained that requirement and expanded the three-day payment window policy to include admission-related non-diagnostic services provided by hospitals and their wholly owned or operated physician offices. Since physician systems are typically separate from hospital systems, this has been and continues to be another challenge, as modifiers have to be added to the physician claims.

Change is continual and it is critical for revenue cycle leaders to be pro-active in these ever- changing times. Seek counsel when needed, obtain guidance from external resources and vow to stay abreast of regulation and challenges today and in the days ahead for both hospital and community.

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Reference

Pear, R. (2012, July 24). Court's ruling may blunt reach of the health law. *The New York Times*. Retrieved from http://www.nytimes.com/Court's ruling may blunt reach of the health law

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CONSIDERATIONS WHEN SUBMITTING A VOLUME DECREASE PAYMENT REQUEST

Strategic Tips for Sole Community and Medicare-Dependent Hospitals

By Stephen C. Sprague, CPA, Reimbursement Consultant, The Rybar Group

In today's ever-changing healthcare environment, it is more important than ever for healthcare providers to ensure they are taking advantage of the various reimbursement opportunities that exist based on regulations and special designations.

The volume decrease payment (VDP) request is one of several reimbursement opportunities that exist for sole community (SCH) and Medicare-dependent (MDH) hospitals. This opportunity is available for an SCH or MDH that experiences, due to circumstances beyond its control, a decrease of more than 5 percent in its total number of inpatient discharges from one cost reporting period to the next. The adjustment was designed to compensate an SCH or MDH for the fixed costs it incurs, and may not be able to reduce, during the year in which the discharge decline occurred. It is important to note the Medicare-dependent hospital program continuation is not guaranteed after Sept. 30, 2012, subject to congressional action.

Many providers face challenges in identifying and successfully adjudicating VDP opportunities. Focusing on four key areas can greatly improve a provider's chances of optimizing its VDP request. These areas are: accurately reporting inpatient discharges, core nursing staff levels, accurate documentation and annual cost report reviews.

The first step a fiscal intermediary/Medicare administrative contractor (FI/MAC) takes in determining eligibility for a VDP is to compare discharges reported on Worksheet S-3 in the Medicare cost report. Many times this statistic is not updated, is inaccurate or is reported inconsistently from year to year and may lead to a missed VDP opportunity or denial of the payment request.

To ensure your facility is correctly reporting discharges on Worksheet S-3, verify that only adult and pediatric inpatient discharges (Med/Surg units, OB and ICU) are included. Do not include the following types of discharges:

- Swing beds
- Newborns
- Skilled nursing facility (SNF)
- Distinct inpatient units (i.e., rehabilitation, psychiatric)

Many hospitals view discharges reported on the Medicare cost report as informational only, with no impact on reimbursement. However, for an SCH or MDH, this figure is vital and should be closely monitored.

The second focus area is the impact core nursing staff levels may have on the calculation of a VDP. The VDP was designed to compensate an SCH or MDH for the fixed costs it incurs during the year in which the reduction in discharges occurred. Such costs include the maintenance of necessary core staff and services.

The relevant regulation and PRM guidance states that not all staff costs can be considered fixed. Some are semi-fixed and may vary somewhat according to volume. Nursing staff in particular is examined closely; a hospital that experienced a decline in inpatient volume must demonstrate that it appropriately adjusted the number of nursing staff based on the decrease in the number of inpatient days. To make this determination, the FI/MAC is required to compare the hospital's actual number of nursing staff with the staffing of like-size hospitals in the same census region. The data used for the comparison is based on either the Occupational Mix Survey or American Hospital Association Annual Survey. If it is determined that a hospital employs more than the reported average number of nurses for hospitals of its size and census region, the amount of the VDP is reduced by the cost of maintaining the additional staff.

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VOLUME DECREASE PAYMENT REQUEST

The reduction in the VDP due to overstaffing can be significant. During a prolonged decline in inpatient volume, full-time employees (FTEs) should be monitored vigilantly and nurse staffing levels reduced, when possible, according to census. This process will help ensure optimal payment under the regulations.

The third focus area is on maintaining the required documentation. The request for a VDP payment must include extensive discharge data, statistical analysis and various cost comparisons. In addition, the provider must document the circumstances related to the discharge decline that were beyond the hospital's control and actions taken during the fiscal year to address the change in volume. Examples of specific activities that may require documentation include:

- Physician practice patterns and related issues
- Cost control efforts
- Events impacting the local economy

Acceptable forms of documentation include minutes from various board of directors and hospital committee meetings, management progress reports related to cost control and physician recruitment efforts or benchmarking reports utilized during the fiscal year.

Many of the procedures and policies to maintain this documentation are likely already in place at most facilities. However, during a year when inpatient volume is declining significantly, extra attention must be given to documenting the issues and actions taken during the year in order to support a potential VDP request.

The fourth focus area is on the cost report. The VDP payment amount is based upon the cost of providing inpatient services to Medicare patients as calculated in the Medicare cost report. When preparing the cost report, certain elections and allocations can be made, consistent with Medicare regulations, that will directly impact the calculation of costs and optimize a potential VDP payment. Even in a fiscal year when there is no VDP opportunity, reviewing the cost report structure is still crucial. Since the VDP payment is limited to the prior year's updated costs, each cost report should be viewed as a possible base year for setting the next year's VDP cap in the event a qualifying volume decline occurs.

The proper calculation of Medicare inpatient costs may also impact a provider's future hospital specific rate (HSR) calculation. CMS does not give advance notice regarding which year will be used as a base year to determine the HSR. The HSR for SCHs was recently re-based using FY 2006 cost report data and went into effect during 2009. Previously, the HSR was based on updated costs from 1996, a time span of 10 years; therefore, ensuring each year's inpatient costs are optimized can have a long-term impact on future Medicare reimbursement. This is particularly important for providers that currently have MDH status. The most recent HSR base year for an MDH is 2002; therefore, if this program continues to be extended, these providers can likely expect an update to the base year in the near future.

Significant declines in volume that result in a low volume opportunity are unanticipated; updates to the re-base year for the HSR calculation are not announced in advance. These unknowns, combined with the reimbursement impact the Medicare cost report can have, highlight the importance of conducting annual cost report reviews as part of a long term strategy to take full advantage of all available Medicare reimbursement opportunities.

An additional item to consider with your VDP request is the recently published SSI rates for use when computing Medicare DSH payments for FYs 2006, 2007, 2008 and 2009. It is important to examine your VDP opportunities for the years that qualify to ensure that accurate documentation is submitted within the 180-day deadline.

The VDP is just one area of opportunity that SCHs and MDHs have for optimizing their reimbursement. It is more important than ever that this and other regulatory opportunities are reviewed and acted on to ensure a healthy financial environment for your facility.

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BDO HEALTHCARE INDUSTRY PRACTICE

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