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THE NEWSLETTER FROM THE BDO HEALTHCARE PRACTICE

BDO KNOWS HEALTHCARE

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STAYING AHEAD OF THE RAPIDLY CHANGING HEALTHCARE ENVIRONMENT

By Steven Shill, BDO USA and Ronald Rybar, The Rybar Group, Inc.

DRASTIC CHANGE IS AFOOT IN THE AMERICAN HEALTHCARE SYSTEM.

As the Affordable Care Act (ACA) goes into effect, and as new technologies, consumer preferences, compliance standards and budgetary pressures take hold, institutions are being forced to adjust their mandates and operating models—making operational improvements, investing in new systems and services, pursuing novel partnerships—to remain viable.

These changes bring with them a host of uncertainties for customers and providers alike. As healthcare organizations look to position themselves for success, grasping the financial and accounting implications of these changes will be essential.

Many of the most pressing challenges ahead for healthcare institutions stem from three key factors: an evolving regulatory environment; shifting reimbursement models; and the desire for long-term sustainability.

Regulatory Challenges

As the nation's healthcare system wades into uncharted waters, the regulatory landscape governing the industry—already one of the

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most complex and onerous on the books—is becoming increasingly difficult to navigate. Disparities between federal and state laws and seemingly perpetual legal challenges—from the Supreme Court on down, often resulting in unusual rulings—have left many organizations shaking their heads as they work to adapt to new federal reimbursement arrangements, readmission penalties and quality-of-care incentives and disincentives.

Indeed, adaptability is paramount, particularly when it comes to accounting considerations for healthcare organizations.

It goes without saying that those with financial and strategic decision-making responsibilities be well-versed in relevant regulatory matters and diligent in monitoring for new rulings. But the ability to react—by estimating the impact of possible rulings, for instance, or ensuring that contingency plans are in place in the event of a major regulatory shift—will be crucial.
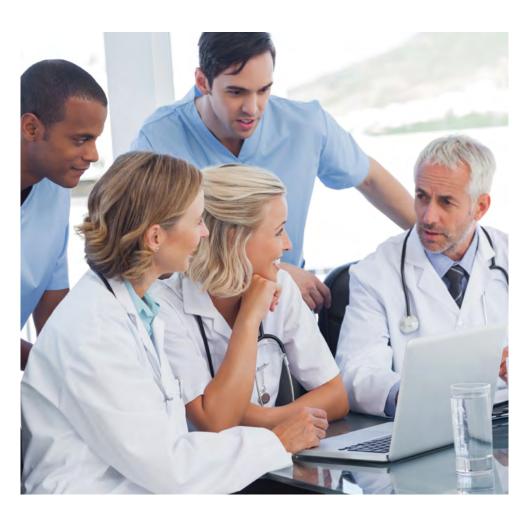
These sorts of unforeseen developments have become commonplace. In response, healthcare organizations would do well to have advanced systems and infrastructure—resources, IT and internal controls—as well as sophisticated training modules in place to guarantee both awareness and compliance with the most up-to-date regulations.

Reimbursement Challenges

With the traditional fee-for-service (FFS) model being increasingly set aside in favor of bundled payment, shared-savings and capitation arrangements as well as a number of other untested reimbursement models and the tightening of belts at the federal and state levels, providers must be prepared to weather considerable volatility and manage the myriad financial and logistical issues that will inevitably arise.

In the case of the bundled payment model—where a primary obligor is responsible for distributing payments to those providing hospital, post-acute, physician services and others—accounting can become tremendously complicated. A number of important questions come to mind:

- What steps can be taken to ensure that a single entity does not become dominant?

- How can partners prevent consolidation for accounting purposes or other unintended consequences?
- What is the best way to establish the appropriate time for bonus payouts?
- How will disputes and other post-period matters be reconciled?

Other reimbursement models bring their own set of challenges, particularly when it comes to budgeting and setting projections, determining and managing risk, outlining contractual sharing arrangements, aligning payment timelines, and handling future litigation. These matters can be daunting and must be considered as healthcare providers evolve and experiment with new and innovative arrangements.

Sustainability Challenges

Hospitals, physician groups, acute care practitioners and other providers are more wary today of their long-term viability than ever before.

Consolidation has long been a popular option for those concerned with sustainability. In the current climate, the practice has taken on new meaning. Hospital-to-hospital mergers are still commonplace in certain parts of the country, but providers are trying new forms of consolidation as well. Successful acute care practitioners have considered joining forces with underperforming ones. For example, hospitals have sought to acquire skilled nursing facilities (SNFs), providers have been picked up by payers in order to create accountable care organizations (ACOs) and hospitals have looked to integrate less successful service lines from other hospitals in order to complement their own successful operations.

Yet, as mentioned, the environment is volatile and many of these ostensible takeovers prove to be merely false starts due to the immense complications of implementation and uncertain prospects for success. Assessing the merit of consolidation is tough business

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and can only really be done on a case-by-case basis, with an eye toward issues of valuation, compliance, purchase price allocation, pre- and post-acquisition contingencies and, importantly, Corporate Practice of Medicine (CPM) concerns.

Private equity, hedge funds and real estate investment trusts (REITs) have become attractive sources of financing for some institutions looking for access to capital. However, the complexities of debt and equity structures, the novelty of real estate investments, the burdens of reporting and the loss of autonomy for hospitals and other organizations entering into these arrangements should all be carefully considered before pursuing these options—and considerable CPM issues are at stake here, as well.

For those hospitals consumed by crisis, there is always the option of declaring bankruptcy with an eye toward emerging leaner and more viable. But this outcome is by no means guaranteed. Indeed, bankruptcies tend to be far costlier and unpredictable than most imagine they will be, and must be very diligently contemplated.

Of late, a number of healthcare organizations have instead pursued strategic alliances: a fresh approach to help alleviate costs through clinical integration, infrastructure sharing and joint purchasing arrangements. In these partnerships, hospitals retain their independent decision-making capabilities, traditions, culture and legacies—all of which are crucial, and tend to be responsible for much of the difficulty in effectively implementing mergers—while simply aligning business practices and strategies with like-minded organizations.

The Cleveland Clinic and Community Health Systems are experimenting with this approach, as are Highmark and the Jefferson Regional Medical Center in Pennsylvania, and a host of other organizations.

As with other novel approaches, of course, the devil is in the details. The structure and effectiveness of coordinating bodies, cost-sharing concerns and the long-term viability of such partnerships must all be on organizations' radar from the outset.

PErspective in Healthcare

The healthcare industry is experiencing a complete shift as new reimbursement models, a new paradigm for the uninsured, an aging population and changes mandated under healthcare reform have all combined to reshape the industry. Amidst all of this change, many healthcare providers have turned to consolidation as they look for new partnerships to provide higher quality and more efficient care to the communities they serve. In fact, a recent report by the American Hospital Association found that more than 550 hospitals have been involved in a merger or acquisition since 2007.

In this robust consolidation environment, private equity has played a significant role – perhaps most notably through increased investments in non-profit hospitals. As with any company or industry, private equity funds can bring essential capital to non-profit hospitals. However, this is particularly crucial for non-profit healthcare organizations that are competing in a saturated market alongside large, public health systems. These hospitals are also facing new regulations under healthcare reform that require significant changes and without the necessary capital, it can be nearly impossible to comply.

Correspondingly, one of the primary reasons some non-profit hospitals are turning to private equity investors is for the capital required to secure critical IT platforms that provide the connectivity that is essential under healthcare reform. Additionally, private equity funding is being sought to enable the significant investments in infrastructure required to deliver better care at lower costs.

While private equity sponsorship may come with significant operational changes, it doesn't necessarily require a complete overhaul of a provider's mission. In fact, private equity partnerships can allow for non-profit hospitals and health systems to revert to non-profit status once the private equity fund exits its investment. The ability to maintain a non-profit legacy makes the involvement of private equity a win-win –- the private equity firm is able to make operational improvements and garner a return on its investment, which, in turn, repositions the non-profit to remain sustainable and competitive in today's rapidly evolving healthcare environment.

PErspective in Healthcare is a feature examining the role of private equity in the Healthcare industry.

Transformation is the name of the game in healthcare today. Regulation, reimbursement and the quest for long-term viability are changing the face of the industry. For those organizations looking to prosper, diligence, openness and adaptability will be key.

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4 QUESTIONS TO ASK WHEN DEVELOPING A NEW HEALTHCARE DELIVERY STRATEGY

By Patrick Pilch, BDO Consulting and Sabrina Rodak, Becker's Hospital Review

The mantra "from volume to value" has been repeated long enough that most hospitals and health systems realize the need to change the traditional way of delivering care. But what exactly should this new model look like, and how can providers get there? Patrick Pilch, managing director of BDO Consulting and former vice president of managed care and new business development at Great Neck, N.Y.-based North Shore-Long Island Jewish Health System, shares four of the many questions hospital and health system leaders should ask when developing a strategic plan for new care delivery models.

According to Mr. Pilch, answering these questions while also evaluating the numerous considerations that come with developing a new healthcare delivery strategy, including physician alignment, payor strategies and IT requirements, will help healthcare leaders develop a roadmap to future success.

1. What are the needs of the community?

A good starting point for developing a new healthcare delivery model is to assess the needs of the community and the demographics of the patient population. The patient population needs to be examined to determine the right care, in the right setting and at the right time along the continuum of care, Mr. Pilch says. As the population ages and as patient needs evolve, healthcare providers will need to reevaluate the community's needs and adapt their care models accordingly.

2. Where are we, and where do we need to go?

Healthcare leaders need to evaluate their organizations' current and desired role in the community to begin developing strategic plan objectives. They should ask questions such as, "What are the community's needs?," "What are our deficiencies in key services?" and "Knowing this, how do we build out?," according to Mr. Pilch. He says healthcare leaders should "focus on where they need to be in three to five years and build toward that. At the same time, they must continue to focus on day-to-day operations to make sure they're not losing the gains they've made in terms of the transition period, aligned cost structure and performance improvements." He also suggests leaders examine their hospitals' mission and vision and ensure their new healthcare model remains consistent within that framework.

3. What skills do I have, and what do I need?

After developing short- and long-term goals, hospital leaders need to assess their organizations' capabilities for meeting these goals. A critical tool in any care transformation project is data. Leaders need to determine their hospitals' data analytics abilities, and if necessary, identify partners that could help provide analytics and decision support services, according to Mr. Pilch. In addition to data capabilities, leaders need to evaluate their hospitals' clinical strengths and align with other providers to help meet the healthcare needs of the community.

4. How can I provide care in the most appropriate setting?

To meet healthcare reform's goals of high-quality care and better patient out- comes while lowering the cost of care, healthcare providers need to seek ways to deliver care in the right place and at the right time. Many hospitals are focusing on preventing unnecessary emergency department visits by providing easy access to outpatient options, such as urgent care clinics, and enhancing their primary care service and chronic disease management offerings. Diverting unnecessary ED visits to outpatient locations can reduce costs, ED crowding and wait times.

In addition to better patient outcomes and higher-quality care, the cost savings opportunities of providing care in the most appropriate setting are leading many hospitals to develop and implement an ambulatory care strategy, according to Mr. Pilch. Hospitals need to consider their options for entering the ambulatory care market and how they can expand their services to preventive, wellness and chronic disease management services, he says.

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HEALTHCARE IN THE CLOUD

By Patrick Pilch and Michael Barba, BDO Consulting

CLOUD COMPUTING IS ONE OF THE LATEST AND HOTTEST INFORMATION TECHNOLOGY (IT) TOPICS IN THE INDUSTRY.

With the development of the cloud, Internet Service Providers like Google and Yahoo provide cloud storage for registered users to store and access their e-mail, calendars and documents. Additionally, Apple hosts the iCloud, which permits iPhone, iPad, Mac and even iPod Shuffle users to safely store their music, pictures and apps as well as quickly sync up all Apple devices. Whether it is one of these service providers or a host of others, the cloud has made it easy for end users to retrieve, restore and access documents, music and video files and, now, your medical history and information.

The healthcare industry's adoption and use of the cloud has accelerated, mainly due to the high cost of care for chronic diseases and reduced reimbursement under healthcare reform in the United States. In its report, *An Unhealthy America: The Economic Impact of Chronic Disease*, the Milken Institute quantified the costs of chronic disease in the United States in 2003 to be approximately $1.3 trillion and projected that the costs in 2023 would be more than $4.1 trillion. Additionally, as healthcare reform shifts reimbursement from fee-for-service to improved patient outcomes and lowered total cost of care, there is a greater need for useful and efficient technology such as cloud computing.

Cloud computing for healthcare would mean that patient information is stored in a "cloud" or an amalgamation of applications, infrastructure and platforms. It is synonymous for distributed computing over a network and allows for the ability to run a program on many connected computers at the same time. The popularity of the term can be attributed to its use in marketing to sell hosted services across a distributed network.

Cloud computing is divided into three categories:
- Infrastructure-as-a-Service (IaaS)
- Platform-as-a-Service (PaaS)
- Software-as-a-Service (SaaS)

Although all three categories make up a complete cloud environment, IaaS allows businesses to deploy and manage network servers and storage in remote locations, run by other service providers, without the significant investment in hardware and real estate needed for on-site facilities. These types of services allow large organizations to eliminate the need for capital expenditures when it comes to updating system infrastructures and allows for organizations to pay only for what they use rather than housing large file servers that may not be fully utilized. Scalability is also a key benefit of cloud computing. Paying for what an organization needs when they need it, adjustments and increased server capacity can be completed within a few minutes rather than several days of on-site labor.

Advantages of Healthcare in the Cloud

Technology can accelerate the transformative process in any industry. In the healthcare industry, it enables hospitals, physicians, community and post-acute providers to more efficiently transform from discrete facilities of care to fully integrated health networks, leading to population health management models. Another advantage is that patient information can be accessed from anywhere and managed over the Internet so that the ease of access and use can be a distinct advantage. This can be particularly helpful for treating low-income patients with chronic conditions, as they frequently access emergency departments rather than seek preventive care. In Boston, Mass., for example,

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physicians are making virtual "house calls" by placing monitoring devices in their patients' homes to measure their weight, sleep patterns and blood sugar, pressure and oxygen levels. Additionally, leveraging the cloud for patient information consumes infinitesimally less space than the storage and retention of traditional paper medical records.

Disadvantages of Healthcare in the Cloud

Though IT investments are ultimately a cost-effective solution, capital expenditures for IT can be daunting for any healthcare organization. As the challenges of a rapidly changing healthcare environment take hold, the risk in deferring capital expenditures is not only a technology risk but also a business risk. Additionally, as with any new technologies or business models, there are both advantages and challenges to be appropriately considered.

For example, capital investment demands are rarely satisfied in a healthcare organization and the capital needed for in-house systems can be too expensive for many healthcare providers. As a result, many healthcare organizations defer the needed IT capital investment until they build up sufficient funds to invest. While cloud computing is not necessarily inexpensive, it can create the use of capital in a more efficient manner, matching expenses with revenues, rather than

a significant capitalized asset, financed over time.

Some of the additional challenges to "Healthcare in the Cloud" relate to the advantages previously discussed. As information is stored and managed over the Internet, it is necessary to take serious precautions in vendor selection and oversight of authorized users to comply with regulatory requirements and do the right thing for patients. Trust is paramount and a compromise of Protected Health Information (PHI) can have serious consequences. In fact, maintaining a secure environment is a major challenge for healthcare organizations that are leveraging the cloud. The cloud must be compliant with The Health Insurance Portability and Accountability Act (HIPAA), requiring secured transmission of PHI or any "individually identifiable health information," including demographic data that relates to the:
- Individual's past, present or future physical or mental health or condition
- Provision of healthcare to the individual
- Past, present or future payment for the provision of healthcare to the individual*

We often read of identity theft or breaches of firewalls, compromising financial and medical data. Patients, consumers, providers and payers are all rightfully concerned with the disclosure risks of PHI.

Cloud computing has emerged as a model for businesses and individuals looking for convenient and affordable access to servers, network storage and applications, in addition to the rising use of social media (a form of cloud computing). Now, PHI is not only stored in paper records, traditional computing, network and storage media devices, but resides in a cloud environment that can be hosted anywhere in the world. This dimension adds complexity to the selection of the right hosting and security providers.

Human behavior also presents challenges. The differences among generations as demonstrated in varying levels of openness to sharing personal information through social media creates potential ethical challenges to providers, as rising clinicians and participants in healthcare access may have different perspectives and understandings of PHI.

Education and consistent and clear communication is essential. As with any business and new technology or platform such as "Healthcare in the Cloud," providers and payers must begin first with the strategic objective of the future state operating model. From there, a current state operating model must be assessed and confirmed, and an actionable plan must be carefully developed and implemented. All along this process, the strategic objectives must be kept in focus as healthcare organizations move toward new operating models and technology platforms, which drive changes in culture and behavior.

*Source: Summary of the HIPAA Privacy Rule, http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary

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EHR IMPLEMENTATION: STEPS FOR MINIMIZING DISRUPTION TO THE REVENUE CYCLE PROCESS

By Shawn Armbruster, RHIA, The Rybar Group, Inc.

The passage of ARRA and the HITECH Act moved the healthcare industry toward electronic health records (EHR), with a federal mandate of compliance by 2015 for Medicare and Medicaid providers in order to qualify for the incentives and to avoid any financial penalties. With just a year and a half left to implement an EHR, organizations are at differing stages of implementation. Many clinicians and healthcare organizations have completed implementation and are looking forward to or have already received the incentive payments available after having met meaningful use requirements. Due to the federal government's "Go Paperless and Get Paid" initiative, the adoption is increasing each year.

With the industry so focused on implementation of an EHR and meeting meaningful use requirements, many facilities are realizing a negative impact to their bottom line, specifically because of the lack of focus on operational processes that are necessary to minimize the disruption to revenue during this substantial organizational conversion.

Facilities who spend more time in the planning stages before an implementation report centralized revenue streams, improved payment turnaround times, improved charge accuracy and improved integration of revenue cycle processes that are necessary to recouping (some of) the cost of EHR adoption and streamlining the revenue cycle processes.

So what steps should an organization take to minimize disruption to the revenue cycle process before and after an EHR implementation?

Formulate a Unified Revenue Cycle Team with an EHR Readiness Focus

A Revenue Cycle Team should be created, which will be responsible for seeing that the revenue continues to flow through the system efficiently and timely post EHR go-live. This internal group typically consists of representatives from Registration, Scheduling,

Coding, Health Information Management (HIM), Billing, Claims, Clinical Documentation Improvement (CDI), Finance, Information Technology (IT) and any other department identified as having an impact on revenue streams. The value of a unified team approach with a major implementation is critical to the success of the clean-up initiative. Departments will have to collaborate and work closely together to achieve success in pushing through the stagnant accounts and avoiding rework.

Collaborate to Escalate and Complete AR Over 60 Days

The Revenue Cycle Team should collaborate and review any and all current billing backlogs, to include Accounts Receivable (AR) over 60 days. The AR goals should be evaluated and include departmental responsibility, broken out by coding and billing AR days to more closely align with who is responsible for pushing the revenue through at any one given time. Another way to organize follow-up for outstanding accounts is to look at the payor filing limits and the reasons for holding uncoded accounts, for instance.

The focus should be to escalate any higher dollar accounts or those that are in danger of not meeting the payor filing limit to the CFO or executive champion on the Revenue Cycle Team who is committed to supporting the goal of minimizing the impact to cash flow at go-live. Additionally, performing a proactive analysis of undischarged accounts with charges can assist in identifying where your high-dollar accounts are coming from and prioritizing them to the top of the work queues to be worked.

This group should plan and outline steps by departmental responsibility and break down the list for revenue cycle owners to follow up on, as well as hold them accountable at the weekly Revenue Cycle Team meeting. For instance, when working the report for outstanding accounts by payor filing limits, consider decreasing the filing limit within your

reporting tool and focus efforts on getting the older accounts "cleaned up and out the door." Highlighting the report in red and sending the report from the executive champion leading the Revenue Cycle Team can assist in supporting the initiative. Doing this pre-go-live for several months helps to have enough data to set goals from within the new system and allows each department to recognize any major flaws in processes and determine how they might do it differently in the new system. Simply meeting weekly and setting goals can make a huge difference in the ability to bounce back from a go-live as it relates to minimizing the impact to AR. The more work you do before the implementation, the less work you will have to do after go-live to clean up the older outstanding accounts.

Meet To Review Operational Processes and Plan System Build

Outside of the vendor guided meetings, the Revenue Cycle Team should meet to review operational processes and plan system build according to how it believe this should be implemented operationally across departments. The meetings should occur weekly, at a minimum. The focus should be to leverage the EHR as a tool to implement your internal processes and resolve any unpaid claims more efficiently to get paid more timely. Wherever possible, build the system around tried and true processes that have already brought success to your revenue cycle. The team should have an additional focus on partnering together to report and review departmental system build, how it impacts each department's staff and processes, and collaborating together to identify the complete revenue cycle stream through the new system build.

These meetings are important to ensuring operational buy-in and assigning responsible parties to the different elements of the system build and the process improvement changes necessary to keep the revenue flowing after go-live.

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Rework Departmental Policies and Processes Based on System Build

The departmental policies and processes should be reevaluated to reflect how employees work accounts in the new system. Recognizing where one department might rely on another to complete the process and holding meetings about how the revenue will flow efficiently and testing the system with real case examples will help in minimizing the number of issues and hold-ups at go-live.

Continuous Improvement Post EHR Implementation

The EHR should bring order to pre-go-live revenue cycle processes you will work through. Many EHR systems offer the ability to know at any given time where a claim is being held, what is needed to continue to process the claim, and how much time is left to process the claim. System work queues, statuses and flags attached to claims and uncoded accounts, as well as claim "buckets" are utilized to monitor accounts more closely and optimize claims processing and denials follow-up.

Continuous improvement and post-implementation maintenance are critical to continue revenue cycle success. New issues will arise and tracking them through a strategic issues log or portal for all employees to see and know what new updates are coming is influential in recognizing trends, communicating effectively and coordinating follow-up. Most EHRs offer improved tracking and reporting of outstanding AR. Monitor reports daily and weekly as a Revenue Cycle Team to look for any discrepancies and determine if the issue is a system build or operational process issue.

Patience during the Transition Period and Long-Term Success

Yes, there will likely be bumps along the road and the transition will not be smooth. But the more prepared you are and the less outstanding accounts holding up revenue at pre-go-live, the smoother the transition. Be honest with yourself and your staff about what the goals and expectations are at go-live and be patient as it typically takes at least three to six months to bounce back and bring AR back into reach of the pre-go-live goals.

Though the implementation of an EHR is a financially and time-consuming process, it offers long-term benefits as far as overall revenue cycle integrity, with streamlined processes to improve the bottom line. By developing a unified Revenue Cycle Team, and proactively improving departmental processes, the overall experience can be one of success and the impact on the facility's long-term revenue will be a positive one.

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BDO HEALTHCARE INDUSTRY PRACTICE

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