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THE NEWSLETTER FROM THE BDO HEALTHCARE PRACTICE

BDO KNOWS HEALTHCARE

POST-ACUTE CARE M&A – 2014 OUTLOOK

By Dr. David Friend, MBA and Patrick Pilch, BDO Consulting

As the nation's baby boomers age and require more home health and long-term care, acute care providers are increasingly focusing on establishing fully integrated post-acute care networks that are capable of creating a true continuum of care. These networks are typically comprised of skilled nursing facilities, assisted living facilities, physical and occupational therapy providers, and hospice and home health agencies. As acute and post-acute care facilities converge and coordinate, we can expect the following results:

- Fully integrated post-acute care providers will participate in narrow networks with acute care providers and will accept bundled payments;
- These same integrated care providers will have the requisite competencies to participate in ACOs;
- Integrated care providers will have the ability to minimize leakage and provide a tighter set of referrals; and
- Integrated care providers will have the capacity to monitor at-risk patients more effectively than under current models.

Through better coordination of care yielding added capacity, integrated care providers will have the capability to better monitor patients most at risk, better ensuring that patients receive the "Four Rs" of healthcare: the right care, at the right place, at the right time and at the right cost. By abiding by these guidelines, the creation of integrated health networks will reduce unnecessary hospitalizations (admissions and readmissions) and service duplications.

On the other hand, post-acute care providers who do not integrate will likely

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POST-ACUTE CARE M&A

find themselves increasingly shut out of the healthcare marketplace as they will be deemed to be inefficient and costly.

Trends emerging from healthcare M&A

As acute care facilities seek to form integrated networks, we expect mergers and acquisitions (M&A) activity in the post-acute care space to continue at the robust pace experienced in the closing months of 2013.

In conjunction with the steady increase in the number of M&A transactions taking place, we also see a decrease in the overall purchase price-per-square-foot of post-acute care facilities. This is likely due to uncertainties in reimbursement and the oversupply of such facilities relative to future demand.

Interestingly hospitals are not the only entities buying post-acute care providers. In an attempt to fill out complementary offerings, create concentrated geographic coverage, eliminate excess capacity and drive up potential reimbursement rates on a provider basis, post-acute care providers are increasingly acquiring each other.

Further, post-acute care facilities are experiencing a growing need to invest significant sums in electronic medical records and workflow enablement technologies.

Finally, payers are prioritizing better care coordination among dual eligible populations, where the services they can provide often serve as a lower-cost, and higher-quality alternative to the more expensive acute care services these populations have traditionally consumed in the past.

As M&A increases, concerns about healthcare costs and access to care also increase

While acute and post-acute care M&A activity is clearly robust and anticipated to continue through 2014, some question whether these consolidations are actually improving healthcare costs and access to care.

Among the groups voicing concern are the Federal Trade Commission (FTC), which remains wary of the potential formation of market oligopolies, forecasting that the risk of prices for healthcare services will remain high and access to services will become limited.

In addition to concerns about cost, others are voicing fears about M&A activity in this space adversely impacting access to care. The American Civil Liberties Union of Washington state recently spoke out against M&A within the healthcare industry, fearing that a recent string of mergers involving Catholic Health Systems will limit access to women's healthcare, and that secular hospitals acquired by religious-based systems will further limit access to healthcare for women.

As a result of these concerns, we expect an increasingly vigilant FTC to require greater due diligence in the area of antitrust with regard to healthcare M&A. Health systems will increasingly be required to demonstrate that their acquisitions will not increase costs or significantly reduce competition in any given marketplace. We believe this is a bar that the FTC will raise progressively higher in the coming months and years as political backlash begins to build against certain large healthcare systems.

Where is this trend heading in 2015 and beyond?

As the acute and post-acute care industries continue to consolidate, new sectors will emerge as targets for acquisition. This provides opportunities for integrated delivery networks to expand geographically and offer a wider breadth and depth of services, as well as the capacity to absorb financial risk. Urgent care, for example, is poised to see tremendous growth in M&A activity, as the healthcare model transitions away from hospital emergency department use and migrates toward lower-cost and higher-quality urgent care centers and the use of pharmacy-based clinics. We expect momentum to continue to build toward the "Four Rs of healthcare" in post-acute care.

Dr. David Friend and Patrick Pilch are Managing Directors with BDO Consulting and lead BDO's Healthcare Consulting Practice. For more information, please contact David at dfriend@bdo.com or Patrick at ppilch@bdo.com.

▶DID YOU KNOW...

In 2013, long-term care providers sustained more than $7.7 billion in allowable costs, which weren't reimbursed by the Medicaid program, according to a report from the ***American Health Care Association/ National Center for Assisted Living***.

Analysts at ***Bloomberg Industries*** report the pharmaceutical industry lost more than $60 billion in revenue to cheaper generic competition from 2010 to 2012, estimating another $50 billion may be lost in the next five years.

Fifty-four of the 114 low-risk Medicare Shared Savings Programs (MSSP) ACOs that began operating in 2012 reported lower expenditures than projected, according to the ***Centers for Medicare & Medicaid Services***.

Healthcare advisory firm ***Avalere Health*** reports three-quarters of Medicaid enrollees will receive their benefits through a managed care organization (MCO) as of 2015.

According to ***Black Book's*** survey of 464 long-term and post-acute care providers, nearly half of all post-acute care providers forecast being acquired by a more technologically superior organization or corporation in 2015, while 21 percent predict bankruptcy, dissolution or closed services.

In a January report released by the ***Centers for Medicare & Medicaid Services***, investigators examined more than 1.7 million Medicare claims for certain hospital admissions filed in 2008. Thirty-nine percent of these hospital admissions went on to utilize Medicare post-acute services, ranging from $5,700 to $14,500.

Of the eight million Americans who have long-term care insurance, January numbers report that premium costs declined in the past several years for men, while costs for women increased, according to the ***American Association for Long-Term Care Insurance***.

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BUNDLED PAYMENTS: REENGINEERING HEALTHCARE TO INCREASE EFFICIENCY

By Dr. David Friend, MD, MBA and Patrick Pilch, BDO Consulting

ONE OF THE LARGEST OBSTACLES FACING THE DELIVERY OF HEALTHCARE IN THE UNITED STATES IS ITS SILOED AND DISJOINTED NATURE.

The former scenario where a single physician was responsible for an entire family's care and treatment is antiquated and, for the most part, obsolete. Physician-patient relationships that were fostered on the basis of trust and familiarity have been pushed to the wayside as multiple entities can now claim responsibility in delivering a single patient's care. The notion of a single provider receiving a bundled payment in return for functioning as a patient's advocate, dedicated to helping him or her receive the best possible care, isn't as prevalent. Underlying this shift, in part, is the immense variation in treatment throughout the U.S. healthcare sector, which adversely impacts the clinical and financial well-being of patients.

Today's medical advancements are so complex that no one individual, no matter how educated, can stay abreast of all the developments within clinical care. This explosion in knowledge and capability has led to the proliferation of increased specialization of providers to accommodate this development. The splintering of care services created a system where a lack of collaboration and communication between providers resulted in mass treatment variation for patients with similar medical conditions. Highlighting this effect is the upcoming adoption of the 10th revision to the World Health Organization's International Statistical Classification of Diseases and Related Health Problems (ICD 10), which has more than 68,000 diagnostic codes – five times the number of those used in ICD 9. This multifaceted and growing system seems to be evolving without regard to the patient or provider.

Viewed in its totality, the modern day patient's care experience is a series of unconnected, isolated treatments. Patients are too often left in the dark as to how to link their own care goals or treatment plans.

These thin communication lines are a result of providers' narrow perspectives due to their isolated and repetitive work. Furthermore, this fragmented healthcare delivery system does not necessarily provide the patient with a quality treatment routine. As a consequence, patient care becomes uncoordinated, expensive and ineffective.

In January 2013, the Centers for Medicare & Medicaid Services (CMS) announced that healthcare organizations participating in the Bundled Payments for Care Improvement (BPCI) initiative would enter into payment arrangements that include financial and performance accountability for episodes of care. Broadly defined as four models of care, the BPCI links payments for multiple service beneficiaries during an episode of care.

- **Model 1:** Retrospective Acute Care Hospital Stay Only
- **Model 2:** Retrospective Acute Care Hospital Stay plus Post-Acute Care
- **Model 3:** Retrospective Post-Acute Care Only
- **Model 4:** Acute Care Hospital Stay Only

The bundled payment model aligns incentives among clinicians, providers and payers. A virtuous cycle emerges from this model as providers deliver better care, receive more patients, drive down costs and generate higher operating margins. Patients are the ultimate beneficiary as they receive better and more effective care. As an early program participant, Brooks Rehabilitation in Jacksonville, Fla., can already cite improved healthcare quality and cost. Brooks' chief operating officer credits the program with three essential components:

- Care navigators who are responsible for managing a patient's entire episode of care
- Analytical and IT tools that track patient vital, clinical and functional signs
- Standardization of assessments at the beginning and repeat assessments throughout a patient's entire episode of care

Even non-traditional players are employing the bundled payments model. Arkansas Blue Cross Blue Shield partnered with Arkansas Medicaid, the Arkansas Department of Human Services and QualChoice of Arkansas, and intends to move all medical reimbursements to bundled payments.

Put into practical application, bundled payments could be the appropriate

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BUNDLED PAYMENTS

situation for orthopedic procedures, such as hip replacements. In a bundled payment compensation system, a single check would cover all patient-required care including the costs associated with the hospital, the surgical implant, the surgeon's fee, medications, nursing home or assisted living facility accommodations post-surgery, patient physical therapy and home care. It would fall to the providers to determine how to allocate the payment.

Re-engineering healthcare delivery models will increase efficiency. By keeping tabs on improved clinical outcomes, providers will be able to better understand their practices within the context of other providers who form the integrated supply chain required to deliver the patient's full experience of care. Providers should keep in mind the "Four Rs" when constructing their programs: The Right Care at the Right Place for the Right Amount of Time at the Right Cost. Late adopters will find themselves providing services at price points they did not set.

While there is no doubt the shift to bundled payments will require work, providers who move first will be able to gain market share. Additionally, they will establish reputations as value-driven, accountable care providers, ultimately leaving the patient with the largest gain from more effective, quality care.

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WHAT YOU'RE NOT HEARING ABOUT...

THE IMPACT OF THE AFFORDABLE CARE ACT ON PHYSICIANS' NEED FOR COMPLIANCE PLANS

By Laura Lovett, CPC, CPMA, CEMC, Data Integrity & Compliance Consultant, The Rybar Group, Inc.

The Affordable Care Act (ACA) will continue to evolve and morph over the coming months and years. While no one can foresee all the changes the ACA will necessitate, or predict the impact it will have on physician practices, given the anticipated magnitude of its effect on the healthcare delivery system, there are some general points of interest to consider.

While it is not within the scope of this article to present all the details, providers need to be fully aware of the fact that the ACA has granted additional powers to some governmental agencies and strengthened existing penalties in order to combat fraud and abuse. This legislation has created screening steps for new provider or supplier enrollments and requires existing providers to revalidate their enrollment. Part of this process requires providers have a compliance program. At this point in time, the specifics of what is required in those compliance programs and implementation deadlines have not yet been established. What is formally established, however, is the increased amount of civil monetary penalties.

If a provider submits a claim for services that are not supported by documentation, it is considered a false claim. Providers may be charged with the False Claims Act even though they do not have knowledge that the claim is false. It is critical for providers to have compliance plans in place to help mitigate the chance of a false claim, as well as demonstrate their attempt to be in "compliance" in case a charge is brought.

The Office of Inspector General (OIG) provided guidance for voluntary compliance plans long before the ACA, with Federal Register/Vol. 65, No. 194 dated Oct. 5, 2000, *OIG Compliance Program for Individual and Small Group Physician Practices*[1]. For a provider's own protection, it is important to develop and implement, at minimum, the auditing and monitoring portion of the OIG's recommended compliance plan. Once the official requirements for compliance programs mandated by the ACA are released, providers will need to update their existing plans to properly cover all required elements.

The best way for providers to protect themselves is to audit, identify, correct, educate and repeat. The government and other payers are continuously looking for ways to save money and identify potential fraud. One method is to stop paying for unsupported services. Reducing unnecessary and undocumented claims is a key funding source for the ACA.

On the providers' end, this means extreme due diligence and clear documentation of all services so they can be captured and submitted for correct reimbursement. If denials do occur, providers must be assertive and willing to go the extra mile by calling, sending appeals and following up with the OIG in order to receive their deserved reimbursement. The likelihood of claims denial after an appeal is reduced when the documentation is precise and accurate. The best way to do this is for providers to keep close tabs on their documentation and coding as part of their compliance plan as well as staying abreast of the ever-evolving rules that apply to their services based on their payers. Proper implementation of compliance plans are a key component to a provider's success in navigating in this process.

1 http://oig.hhs.gov/authorities/docs/physician.pdf.

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DEMANDS FOR ASSURANCE OVER THIRD PARTY PROCESSORS

By John McLaughlin, CPA, BDO USA

Third party processing organizations spanning a variety of business sectors including healthcare, life sciences, technology, distribution, financial and other services are being requested by their customers (i.e., user organizations) to obtain an assurance report on controls related to the integrity of certain processes and security over sensitive information being handled by those third parties.

Many user organizations realize that while they have outsourced certain aspects of their business, they continue to be responsible for the activities conducted by the third party processing organization. A good deal of this concern has been driven by regulations and standards such as the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health, the Gramm-Leach-Bliley Act, the Meaningful Use standards of the Centers for Medicare and Medicaid Services, the Office of the Comptroller of the Currency's Bulletin 2013-29, the Federal Deposit Insurance Corporation's FIL-44-2008 and others, including various state and international privacy laws.

THE EVOLUTION OF SOC 1 AND SOC 2

Statements on Standards for Attestation Engagements No. 16 (SSAE 16) is an update to the previous standard, known as Statement on Auditing Standards No. 70 (a.k.a. SAS 70) created in the early '90s by the American Institute of Certified Public Accountants (AICPA) in which an auditor would provide assurance regarding specified control objectives over processes related to financial reporting. Service Organization Control No. 1 (SOC 1) reports are conducted using SSAE 16.

AT Section 101 was developed in 2001 by the AICPA to place requirements for CPAs examining and issuing reports on controls over matters ***not*** related to financial reporting. These requirements are codified within AT Section 101, *Attest Engagements*, of the AICPA's attestation standards. Reports issued under AT-101 often utilize the AICPA's Trust Services Principles, which relate to security, availability, processing integrity, confidentiality and privacy.

Lately, many of the audits issued under AT-101 that are gaining prominence in the marketplace include Service Organization Controls No. 2 (SOC 2) and Service Organization Controls No. 3 (SOC 3) reports. Each of the five Trust Services Principles is supported by dozens of criteria and third party processors and may choose to comply with either one, several or all five principles.

Trust Services Principles Overview

SECURITY: The system is protected, both logically and physically, against unauthorized access.

AVAILABILITY: The system is available for operation and use as committed or agreed.

PROCESSING INTEGRITY: The system processing is complete, accurate, timely and authorized.

CONFIDENTIALITY: Information that is designed "confidential" is protected as committed or agreed.

PRIVACY: Personal information is collected, used, retained and disclosed in conformity with the commitments in the entity's privacy notice and with the privacy principles put forth by the AICPA and the Canadian Institute of Chartered Accountants (CICA).

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THIRD PARTY PROCESSORS

▶EXPECTED REVISIONS TO SOC 2 STANDARD

However, in late July 2013, the AICPA issued an Exposure Draft related to the Trust Services Principles and Criteria in which comments were requested by Sept. 30, 2013. Essentially, the AICPA assembled a task force to re-evaluate the Trust Services Principles and Criteria that serve as the basis for a SOC 2 audit. The task force has assembled for a few reasons:

- Increase the clarity of certain criteria;
- Eliminate redundancy among the criteria; and
- Update the criteria based upon the changing technology and business environment as the original Trust Service Principles were derived from the SysTrust principles and criteria.

The Exposure Draft describes the AICPA's Assurance Services Executive Committee (ASEC) rationale and expected changes to the existing standard. The following is a brief summary of what they are contemplating.

Common Criteria: ASEC is recommending the creation of "common criteria" that represent criteria that are applicable to four of the five principles, namely Security, Confidentiality, Availability and Processing Integrity. A number of third party processing organizations have cited overlapping criteria across four of the five principles, and the associated inefficiency. The Common Criteria will constitute the complete set of criteria for the Security Principle and will be organized into seven categories following the key concepts of the Committee of Sponsoring Organizations of the Treadway Commission (COSO) framework, including:

- Organization and Management
- Communications
- Monitoring of Controls
- Risk Management and Design and Implementation of Controls
- Logical and Physical Controls
- System Operations
- Change Management

Separate Criteria: For the principles of Availability, Processing Integrity and Confidentiality, a complete set of criteria will be comprised of all of the Common Criteria and all of the criteria applicable to the principle being reported upon. For instance, the Exposure Draft indicates the principle of Availability will have three unique criteria; Processing Integrity will have six unique criteria; and Confidentiality will also have six unique criteria.

Privacy Principle: The Privacy principle will remain distinct and is being revised by a separate task force. An exposure draft has not been created related to Privacy at this time.

Risk Assessment: ASEC appears to be emphasizing an assessment of risks that any particular criteria will not be met. Appendix B of the Exposure Draft provides illustrative examples of criteria and controls, and their corresponding risks. It is possible that Sections 3 and 4 of the SOC 2 report may require more information regarding management's assessment of risks. However, we'll have to see what the final version of the Trust Services Principles entails.

The AICPA is indicating that the new reporting standard will go into effect for periods ending after Dec. 15, 2014. However, earlier adoption will be permitted when the final standard is released in 2014.

John McLaughlin, CPA, is a partner with BDO USA, LLP responsible for SOC engagements and providing clients with governance, risk and control advisory services. He can be reached at jmclaughlin@bdo.com.

PErspective in Healthcare

With the volume of private equity "dry powder" hitting record heights late last year, according to ***Reuters***, private equity firms are focused on spending this capital, and healthcare remains a prime target. Within the healthcare industry, the pain management and anesthesia sectors are drawing particular attention from investors.

According to the **U.S. Department of Health and Human Services**, more than one in four Americans suffers from pain that lasts longer than 24 hours and millions more suffer from acute pain. Affecting more Americans than diabetes, heart disease and cancer combined, chronic pain is cited as the most common reason Americans access the healthcare system.

While private equity investment in pain management clinics has been a trend since 2010, more significant levels of investment emerged in 2013.

Anesthesia is another area poised for growth in the coming year. According to ***Becker's Hospital Review***, a number of private equity firms, including Madison Dearborn, Blackstone Group, Provident Healthcare Partners and Goldman Sachs Private Capital Investing Group, have made significant investments in anesthesia practices. And this list is expected to grow in 2014.

Private equity investors are drawn to pain management and anesthesia for a number of reasons. First and foremost, the aging baby boomer population means a likely increase in surgical services in the coming years. Pain management clinics and anesthesia practices typically enjoy regular cash flows, and can be used to finance future acquisitions. Additionally, these businesses are relatively immune to market cycles, and they are typically good franchise candidates, providing competitive advantage as they build economies of scale.

While prognosis for private equity investment in these sectors is good, it is not without risks. As healthcare reform reduces traditional reimbursement, pain management and anesthesia clinics will be under greater pressure to reduce costs.

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

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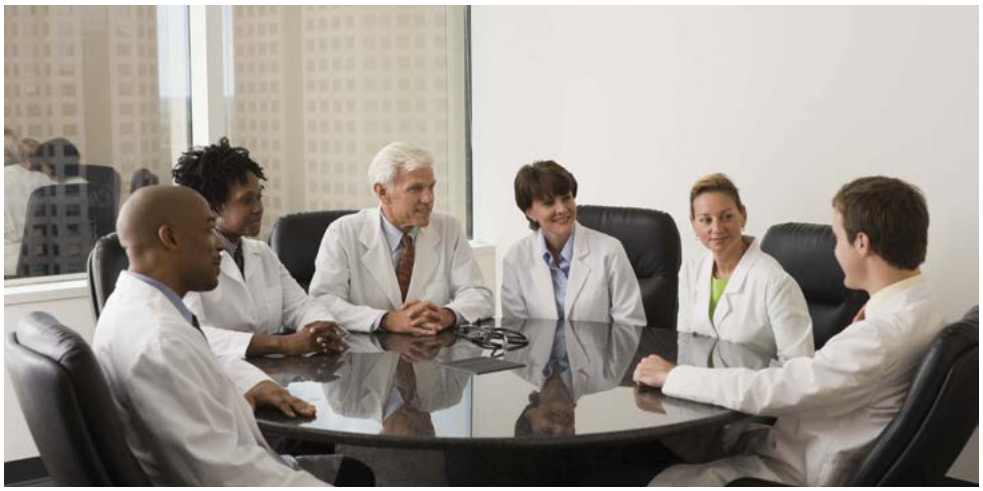
WAS INTERNAL REVENUE CODE SECTION 501(R) A WAKE-UP CALL FOR TAX-EXEMPT HOSPITALS TO FOCUS ON THE HEALTH OF THE PATIENT POPULATION?

By Dr. David Friend, MD, MBA and Patrick Pilch, BDO Consulting

A *Time* magazine cover article estimated that the value of all tax exemptions given to hospitals by federal, state and local authorities exceeds $80 billion a year. Many healthcare institutions have simply taken for granted that they will continue to receive tax exemptions, despite the fact that they have grown into large, multifaceted enterprises, often with financial interests in many for-profit initiatives. However, as government budgets have come under increasing pressure, many government entities are once again asking: Why do these institutions receive such large tax exemptions, and what contributions are they making to society in return?

It is important for tax-exempt healthcare institutions to recognize that they are under an increased level of scrutiny to demonstrate social responsibility. One tool that tax-exempt hospitals can use to demonstrate the validity of their tax exemption is the implementation of a Community Health Needs Assessment (CHNA), a report nonprofit hospitals are required to conduct by section 501(r) of the Internal Revenue Code. Failure to comply with section 501(r) can result in both fines and the potential loss of an institution's tax-exempt status. Instead of viewing compliance with 501(r) as a cost of compliance, it should be seen as an opportunity to grow revenue through patient population management so that institutions can improve relationships with their communities, preserve their tax-exempt status and grow their bottom lines.

Developing a stronger CHNA requires a focus on managing the care of specific populations in the communities served, which in turn allows an institution to develop tools to identify those individuals who are more likely to require emergency room visits or expensive interventions. With this information, a hospital can help reduce inappropriate re-hospitalizations, prevent unnecessary admissions, provide more appropriate access to care and improve outcomes and the value of the care it delivers.



In order to develop a sound population management capability, institutions will need access to finance and data analytics, specialists with resources in clinical operations and a keen understanding of the nuances of the regulatory environment. These components, leveraged effectively, may allow tax-exempt institutions to grow their market share while increasing revenue and margins which can, in turn, be reinvested.

Despite these benefits, it is often difficult to determine where to start. Here are some suggested steps for improving your CHNA:

1. Use an outside group to conduct the CHNA

Healthcare organizations can capitalize on local university resources. For example, Akron Children's Hospital, Akron General Medical Center and Summa Health System contracted Kent State University College of Public Health to study the needs of populations in the communities they serve. Topics addressed ranged from chronic illnesses and lifestyle factors to mental health and substance abuse. Input from community leaders and residents was instrumental in developing community health initiatives. As a result of the assessment, Children's Hospital has begun developing a plan to help primary care doctors better identify young patients with asthma.

2. Increase community transparency

Chattanooga's Hutcheson Medical personally and directly engaged its local community by conducting an online survey where residents were able to express their thoughts on health, nutrition and access to care. This direct feedback will allow the hospital to closely tailor its assessment and initiatives to the specific needs of residents.

3. Perform a "mock audit"

Determining areas of weakness – either financial or medical – can be enlightening for many institutions. It allows them to identify inefficiencies and reallocate resources to best serve their constituents before they catch the eye of the IRS, in turn helping the institution maintain its exempt status.

We believe the sooner institutions embrace 501(r) as a tool for growth rather than as a cost of compliance, the more successful institutions will be going forward.

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MARK YOUR CALENDAR...

MARCH 2014

March 24-27
Congress on Healthcare Leadership
Hyatt Regency Chicago
Chicago, Ill.

APRIL 2014

April 5-9
ACHCA's 48th Annual Convocation and Exposition
The M Resort Spa & Casino
Las Vegas, Nev.

April 7-9
The 11th Annual World Health Care Congress
Gaylord National Resort and Convention Center
National Harbor, Md.

April 11-13
ASHA Health Care & Business Institute 2014
Green Valley Ranch Resort Spa Casino
Las Vegas, Nev.

April 25-28
2014 ACPE Annual Meeting & Spring Institute
Chicago Marriott Downtown Magnificent Mile
Chicago, Ill.

MAY 2014

May 12-13
ACHE's Leaders Conference
Loews Vanderbilt Hotel Nashville
Nashville, Tenn.

May 18-21
The 5th Annual Patient Experience: Empathy & Innovation Summit
Cleveland Convention Center
Cleveland, Ohio

May 19-22
ALFA 2014 Conference and Expo
Phoenix Convention Center
Phoenix, Ariz.

JUNE 2014

June 5-8
2014 CAPG Healthcare Conference
JW Marriott at L.A. Live
Los Angeles, Calif.

June 12-13
2014 HASC Health Care Provider Wellness Conference
Disney's Paradise Pier® Hotel
Anaheim, Calif.

June 22-25
HFMA's 2014 National Institute
The Venetian and The Palazzo Hotel-Resort - Casino/Sands Expo Center
Las Vegas, Nev.

BDO HEALTHCARE PRACTICE

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- Home Care and Hospice
- Hospitals
- Integrated Delivery Systems
- International Health Research Organizations
- Long Term Care
- Physician Practices
- Preferred Provider Organizations (PPOs)
- Senior Housing, including CCRCs

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