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THE NEWSLETTER FROM THE BDO HEALTHCARE PRACTICE

BDO KNOWS HEALTHCARE

REORGANIZING THE LONG TERM CARE INDUSTRY TO MEET THE CHANGING MEDICAL, DEMOGRAPHIC, TECHNOLOGICAL, ECONOMIC AND REGULATORY LANDSCAPE

By David Friend, MD, MBA, BDO Consulting, Timothy Walsh, JD, MBA, and Jeremy Johnson, JD, McDermott Will & Emery LLP.

A new paradigm for long-term care is emerging and is radically altering the future of skilled nursing, transitional care and assisted living facilities. It is being driven by changes in medical care, demographics, technology, economics, including but not limited to reimbursement changes and regulations.

THE CURRENT LONG TERM CARE SYSTEM

In the U.S. today, there are approximately 15,700 nursing homes or skilled nursing facilities (SNFs) comprising of approximately 1.7 million beds with an average facility age exceeding 30 years, according to the National Center for Health Statistics. The costs for residents at these facilities are borne by a combination of Medicare, Medicaid and private pay. We estimate the aggregate annual payments made to SNFs to be $110 billion, including approximately $20 billion from private pay, $30 billion from Medicare, and $60 billion from Medicaid.

The payment system is complicated. For example, the existing Medicare benefit pays a maximum of 100 days and the reimbursement averages around $500 per day. Once residents have reached the maximum stay, they are not eligible for Medicare benefits again unless they have been out of the SNF for at least 90 days. Residents that require skilled nursing care beyond 100 days, or require a return to

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a SNF before the 90 day waiting period has passed, must pay privately or, if impoverished, be placed on Medicaid. The existing Medicaid benefit is significantly less than Medicare and averages around $250 per day, which is estimated to be only 90 percent of the daily cost of caring for a SNF patient. The costs of private pay are significantly more.

In response to the aging SNF inventory, new owners are beginning to construct a particular kind of SNF, offering transitional care and services not historically provided. These "new-style" SNFs are referred to herein as modern advanced skilled nursing facilities, or MASNFs. MASNFs are providing better outcomes, shorter lengths of stay and fewer rehospitalizations than traditional SNFs.

▶THE FUTURE OF LONG TERM CARE

MASNFs will have a profound impact on the long term care industry. According to the Centers for Medicare & Medicaid Services, there is tremendous variance in expense and length of stay that cannot be explained by a divergence in medical conditions. As a result, payors seek to improve care and reduce costs by focusing on outcomes measures, length of stays and rehospitalization rates. Managed care and accountable care organizations (ACOs) are beginning to drive patients away from traditional skilled nursing facilities to MASNFs through the use of ever narrowing networks and are beginning to redirect their patients from traditional SNF operators with poor outcomes and long lengths of stay to MASNFs.

As ACOs, bundled payments and other incentives gain traction, we estimate that aggregate demand for bed days will be reduced by more than six percent per year, resulting in a reduction of over $30 billion dollars per year in payments to SNFs by the end of 2019. The reductions in aggregate demand, combined with market share losses incurred by poorly performing operators, will likely drive many of the 15,000 older SNFs to operating losses. This will cause widespread defaults and create the demand for creative restructuring solutions in 2015 and beyond, including closures, mergers, and other alternative solutions, both in and out of court.

Importantly, the $30 billion reduction in aggregate payments will not occur evenly across the entire spectrum of long term care providers. Newer facilities offering modern advanced skilled nursing care managed by smart operators that can provide superior clinical outcomes and customer satisfaction will thrive and take an increasingly larger share of this shrinking market while older SNFs will be disproportionally impacted and risk failure.

In addition to the effect on the long term care market, demand for traditional surgical and medical hospital bed days will also fall as patients are moved to lower cost and equally clinically effective MASNFs offering transitional care. ACOs and managed care operators will require hospitals to discharge patients who would previously have stayed in hospitals after their medical or surgical procedures, to lower cost MASNFs (that can offer care previously available only in hospitals) for short stays while enabling patients to recover from medical or surgical care.

A combination of economics and technology drives this change as technology allows treatment in lower cost settings – MASNFs can be built and operated at less than a third of the cost of a traditional hospital. The economic advantage of moving a patient from a $3,000-a-day hospital bed to a $1,000-a-day MASNF bed is compelling. If every one of the 36 million patients admitted to a hospital could substitute just one hospital bed day for one transitional care day, the potential savings could exceed $72 billion annually.

Unfortunately, in many cases, the only non-hospital facilities currently licensed to offer MASNF-level care are traditional SNFs, which typically lack the technology, infrastructure or staff capable of providing an additional level of care and will never be able to make the leap. SNFs risk being left behind with few options outside of closure, sale or restructuring. Thus, despite the glut of older SNFs, there will simultaneously be a significant demand for, and serious shortage of, MASNFs with the capabilities of delivering transitional care.

Encouraging the necessary investment in MASNFs and clinical programs is challenging given the uncertainty around reimbursement and regulation in the marketplace. The rate

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limiting steps will include how quickly ACOs, CMS and managed care can exert economic influence over the providers. In states with certificate of need requirements, this process will likely move even slower, but the economic and clinical realities are compelling.

Our analysis suggests the need for the construction of 100,000 new MASNF beds to handle demand from former hospital patients over the next 10 years as ACOs and other incentives gain traction. At an average cost of $100,000 per bed, there will be a need of at least $10 billion in new construction. However, with an estimated savings of nearly $70 billion per year, the return on investment clearly justifies the costs.

In the coming years, we predict that a combination of regulatory changes (including potentially new forms of licensing and revised/relaxed certificate of need requirements) will be hotly debated by state legislatures. While legislatures are rewriting the rules, the markets will be grappling with extensive restructuring of older SNFs and development of MASNFs.

▶DEMOGRAPHICS WILL SIGNIFICANTLY IMPACT LONG TERM CARE DEMANDS.

The number of people needing care for dementia is exploding and we are not prepared. Demographics will provide additional pressure on the long term care system. One in eight Americans over the age of 65 suffer from some form of dementia. This number is expected to more than double over the next 25 years from five million persons afflicted currently to 11 million individuals (2012 Alzheimer's Disease Facts and Figures) by 2040. These individuals will likely live on average for over 10 years and have at least five comorbidities, which make them medically complex.

There are currently estimated to be 31,100 assisted living facilities with 972,000 beds supplying long term services and support (LTSS), including room and board, basic health monitoring, incontinence care, social recreational activities, special diets, laundry and other ancillary services. These facilities are not licensed or designed to care for individuals who need regular nursing care yet an increasing number of increasingly frail patients are beginning to occupy these beds at an average rate of $42,600 per year. Those with dementia are paying over $57,000 per year because they require additional services, such as care management and monitoring, assistance with activities of daily living, housekeeping and laundry, medication management, recreational activities and transportation.

Approximately 20 percent of patients living in assisted living facilities are covered under Medicaid section 1915(c) waiver program provided by 35 states, which permits the use of state funds at community-based facilities that traditionally could only receive private pay. Collectively, Medicaid is paying $1.7 billion annually or $31,000 for each of the 54,000 Medicaid beneficiaries in 12,000 facilities. The remaining 80 percent of the nearly one million beds are being occupied by private pay patients spending over $35 billion.

The doubling of the number of Americans with dementia will profoundly affect the long term care system. Dementia patients will need places to live and require treatment. Paying for such services will present a significant challenge in the long term care industry. For example, if just 20 percent of the increased population with dementia ends up requiring LTSS, there will be a need for the construction of an additional one million beds. At a cost of $100,000 per new bed, an additional $100 billion must be spent on new construction investments in new facilities and an additional $60 billion per year on providing a very basic package of health services to these individuals.

With this segment of the long term care industry is currently virtually unregulated, we expect legislatures to debate the governance and financing of these facilities as they increasingly seek to care for residents with acuity levels formerly seen only in licensed skilled nursing facilities and hospitals. Further, with an increasing percentage of these individuals unable to afford the cost of care from personal funds, the pressure on government to do something on the financial front will be intense.

▶WHAT DO WE DO NEXT?

We believe that these three forces: (1) the dramatic reduction in demand for older SNFs, (2) the significant increase in demand for MASNFs providing transitional care, and (3) the increase in demand for care for patients with increasing numbers of elderly, frail and sick individuals are beginning to radically alter the long term care/post-acute care industry. We expect these changes to significantly impact the long term care industry for the next decade.

To cope with decreased demand and increased competition, current SNFs must restructure their existing debt obligations and obtain access to additional capital to upgrade their facilities to compete with MASNFs. Some SNFs may be forced to recognize that their most valuable asset is the certificate of need and consider radical solutions to comply with applicable fiduciary duties.

The key to successfully dealing with these issues is a proactive multidisciplinary approach to the challenges facing the long term care industry including retaining professionals with financial acumen, clinical expertise, technical skills and legal/regulatory/policy knowledge. We are confident that we can build a much better health care system with this approach…and without a doubt, we need to do so.

1. National Health policy forum Jan 2013 George Washington University

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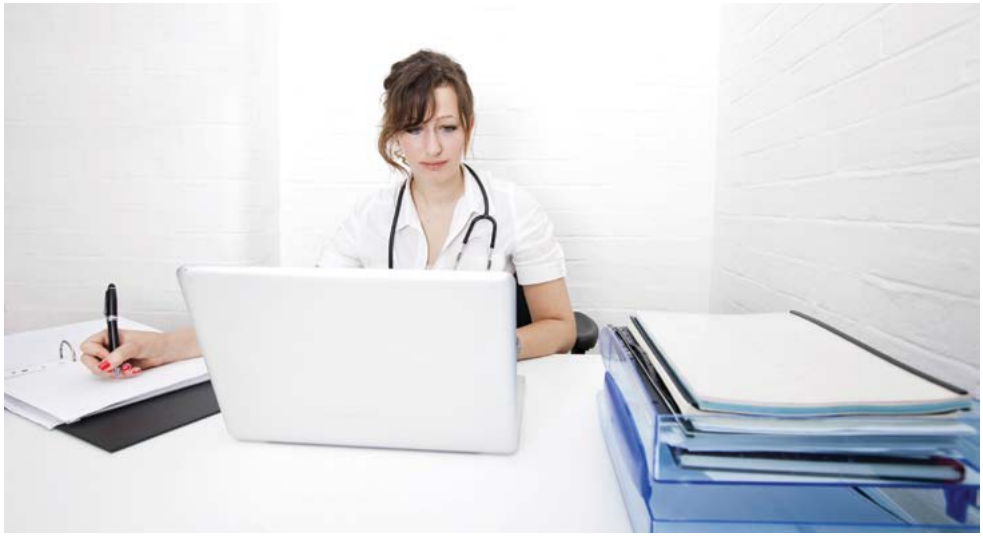
ICD-10 DEFERRAL: WHAT'S NEXT FOR PROVIDERS?

By Steven Shill, BDO USA and Laura Lovett, CPC, CPMA, CEMC, The Rybar Group, Inc.



On March 31, it was with great surprise that the Department of Health and Human Services (HHS) announced that the mandated conversion to the International Classification for Diseases, 10th Edition (ICD-10) was to be further delayed through Oct. 1, 2015. This delay is part of a larger bill which is focused on preventing a significant cut on Medicare reimbursement for physicians.

What Led to the Delay to Implement ICD-10 in the U.S.?

A number of factors led to HHS's decision. For one, implementation is costly. The American Medical Association (AMA) estimates that costs could be $225,000 for a typical small physician's practice and as much as eight million for a large practice.

Second, industry experts question whether the medical community is prepared to implement ICD-10. The Medical Group Management Association (MGMA) noted that in February 2014, only 10 percent of physician practices were in fact ready for ICD-10 implementation.

According to research conducted by MGMA, the overall readiness of the industry remains slow. In a press release, the association noted that "The transition to ICD-10, with its substantial impact on documentation of clinical care, physician productivity and practice reimbursement, is unprecedented. It's proving to be one of the most complex and expensive changes our healthcare system has faced in decades."

Additionally, in today's shifting healthcare environment, it is no wonder a significant percentage of physicians are resisting the implementation of ICD-10, as it is just another of the many financial shocks facing doctors. According to MGMA, "ICD-10 will arrive at the same time that a number of other transformative federal policies go into effect, such as health insurance exchanges and Stage 2 of the CMS Meaningful Use EHR Incentive Program."

What Was the Industry's Reaction to the Delay?

According to a recent poll conducted by *Healthcare Informatics*, 59 percent of providers expect a loss of momentum due to the delay and 58 percent expect their resources and funding to be most affected. Fourteen percent of providers said the delay will give them time to catch up on testing for the new coding system. The Coalition for ICD-10, a broad-based healthcare industry advocacy group that includes hospitals, health plans, physician office coding experts, vendors and the health information technology (HIT) community, sent a letter to HHS encouraging the department to reconsider its October 2015 deadline. For the time being, HHS is sticking to its deferral.

What Can Providers Do Now to Prepare for ICD-10 Implementation?

As with most new ventures in the medical field, the challenge is adapting to the requirements. The time invested now will save effort, energy and, in the long run, money.

There are several resources available to help prepare for the implementation of ICD-10. Most of them focus on how to prepare the coders and billers for the transition. While it is important to work with these individuals to ensure they have the necessary training, it is equally important for providers to understand what they need to do in order to be ready. Providers need to take a long, hard look at their documentation as this is where the true impact of ICD-10 implementation will be felt by clinicians.

That is not to say that providers will be on their own in understanding the new documentation requirements. Nor does it mean it has to be a painful, difficult or monumental undertaking. Providers are not expected, or even encouraged, to memorize any ICD-10 codes. Rather, they are expected to take care of their patients and document what they did, then codes will be assigned based on documentation.

In advance of ICD-10 implementation, providers will need to gather and document more information on most of their patients. To help capture all necessary data, providers might consider creating a documentation-prompting template, a tool they can refer to until they are comfortable with the new requirements. This template is not meant to replace a provider's documentation style; rather it is intended to prompt providers to capture all the required elements in order to assign the appropriate ICD-10 code to the highest level of specificity.

A documentation-prompting template can be created by the providers' organization or by outside consultants. Providers do not need a template for each and every diagnosis code, but they do need a template for the main category that encompasses all possible options. For example, say an organization has

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ICD-10 DEFERRAL

more than 50 different fracture codes that it is currently reporting in ICD-9. It would only need one template for fractures, as they all follow the same basic setup in ICD-10. A fracture template may look something like this:

Fractures – General Guidelines:

If not specified as displaced or nondisplaced, coders will default to displaced.

If not specified as open or closed, coders will default to closed.

Needed information (if applicable):

1. Location – e.g., proximal end, mid shaft, etc.
2. Laterality
3. Bone(s) involved – e.g., ulna alone or ulna with radius
4. Type of fracture – physeal, comminuted, spiral, transverse, etc.
5. What encounter this is – e.g., initial or subsequent
6. Healing status – routine, delayed, nonunion, malunion, sequel

Example of what a code actually states:

S72.021N Displaced fracture of epiphysis (separation) (upper) of right femur, subsequent encounter for open fracture type IIIA, IIIB, or IIIC with nonunion

What's Next?

Changing to ICD-10 is not as easy as flipping a switch. The U.S. healthcare industry must reshape 35 years of habit, and it will take time to adjust. However, with the additional allotted time, it is prudent that providers ensure that documentation will be ready to go live once October 2015 approaches. Their alternative — to wait and then spend a great deal of time re-visiting records and amending notes just to get claims out the door or, better yet, paid — makes much less sense.

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BDO'S EXPANDED HEALTHCARE ADVISORY PRACTICE

New reimbursement models, an aging population and changes mandated under healthcare reform have all coalesced to reshape the industry, placing tremendous pressure on healthcare organizations to adapt, drive efficiencies, manage costs and improve the quality of care for patients.

Within this new healthcare landscape, the need to transform business and care models is paramount. BDO recognizes this challenge – and opportunity – and we're committed to continuing to grow the breadth of services we provide to healthcare clients to help them navigate this complex environment and position themselves for success.

We are pleased to announce the continued expansion of BDO's Healthcare Advisory practice and BDO's Center for Healthcare Excellence & Innovation, with the addition of three leading industry professionals:

- **Dr. David Friend, MD, MBA:** Managing Director with BDO Consulting and Chief Transformation Officer for BDO's Healthcare Advisory practice, where he co-leads Clinical Strategy for the firm's Center for Healthcare Excellence & Innovation.
- **Dr. William "Bill" Bithoney, MD, FAAP:** Managing Director with BDO Consulting and Chief Physician Executive for BDO's Healthcare Advisory practice, where he co-leads Clinical Strategy for the firm's Center for Healthcare Excellence & Innovation.
- **E. Venson Wallin, Jr., CPA:** Managing Director with BDO Consulting, where he expands the firm's regulatory and compliance capabilities for BDO's Healthcare Advisory practice and Center for Healthcare Excellence & Innovation.

Dr. Friend, Dr. Bithoney and Mr. Wallin join **Patrick Pilch**, National Leader of BDO's Healthcare Advisory practice, further enhancing the firm's ability to offer clients diverse, multidisciplinary teams that bring together deep clinical, financial, regulatory and data analytics experience to help provide sustainable solutions across the full spectrum of healthcare challenges facing organizations, stakeholders and communities. They will work alongside seasoned BDO Healthcare industry leaders **Chris Orella** and **Steven Shill** to drive value for BDO's healthcare clients.

For more information, please contact Patrick Pilch at ppilch@bdo.com, David Friend at dfriend@bdo.com, William "Bill" Bithoney at bbithoney@bdo.com or Venson Wallin at vwallin@bdo.com.

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FOUR STEPS TO PROTECTING AGAINST AVOIDABLE READMISSIONS

By William Bithoney, MD, FAAP, BDO Consulting

As the maximum financial penalty for hospitals with high readmission rates rises to three percent of Medicare payments in fiscal year 2015 under the Hospital Readmission Reduction Program, hospitals are working to adjust current systems to meet program requirements. Presently, CMS only holds hospitals accountable for readmissions that occur within 30 days after discharge from an initial admission related to acute myocardial infarction, heart failure and pneumonia, but by October 2014, acute exacerbation of chronic obstructive pulmonary disease and elective total hip and total knee arthroplasty will be included. Despite preventable 30-day all-cause readmission rates for Medicare falling to 17.5 percent last year (18.5 percent in 2012), more can be done to effectively manage these numbers. Outlined below are four important steps hospitals can take to manage and improve their current systems of care.

1. EFFECTIVE MANAGEMENT OF CARE TRANSITIONS

The number one cause of medical errors in the United States is poor transitions of clinical care. Researchers have found that inadequate care coordination accounts for $25-40 billion each year in excess care costs, according to a 2012 *Health Affairs* report. Miscommunication with the patient, care management team or the primary care provider can result in dropping the ball and inadequate patient care. To guard against mismanaged transitions, hospitals can:

- **Establish Provider Accountability.** By including all medical records that meet certain minimum standards to transferring the patient's primary diagnosis and problem list to the appropriate parties during the care process, providers set up guidelines for future practices. Having access to detailed accounts of the patient's cognitive status, primary language and reports of critical and pending test results, in addition to properly identifying the primary care coordinating physician, are imperative to seamlessly move patients through the care process. The best care coordination occurs when a provider acts as the "hub" of care. This provider must be ready to supply timely communication to all other care providers, mitigating health and financial risk.

- **Employ IT Effectively.** During any hospital admission, the utilization of clinical practice guidelines and computerized physician order entries are known to facilitate care. For the most seriously ill, physicians should use telemedicine as an early alert tool to notify them of changes in a patient's condition. Technology allows physicians to monitor and conduct real-time clinical surveillance to identify at risk-patients, which can aid in clinical treatment plans. Through electronic medical records, workflow can be streamlined and physicians have access to the latest information for particular treatments, which provides an additional layer of clinical decision support.

- **Assign a Discharge Advocate.** Patients at high risk for readmission can benefit greatly from a coach who is tasked with performing a comprehensive assessment and developing a care transition plan. The plan should include significant information from the hospitalization and guide the patient with post-discharge instructions. The discharge advocate also assumes the role of notifying the appropriate insurance payer and the patient's case management service. Once the patient is discharged, the advocate should maintain interactions with the family caregiver, the primary care provider and the hospital's discharge care manager, as well as a number of other ancillary medical providers, such as pharmacy and nutrition services. Follow-up appointments, as well as interventions, should be coordinated by the discharge advocate given continued involvement in the patient's prognosis. In addition, physicians should work with the discharge advocate to educate the patient about readmission risk and create special programs for those with the highest risk for readmission.

2. STRATIFY PATIENT READMISSION RISK

To best prevent potential readmission, physicians should conduct assessments to identify which patients require the most monitoring. Effective risk stratification will help predict those who need to be monitored more closely with early primary care follow up, transition coaches, telemedicine and

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AVOIDABLE READMISSIONS

other clinical interventions. What's more, segmenting patients into diagnostic coding groups can better help identify patients at risk of admission or readmission. Risk factors for readmission typically fall into three categories: 1) Patient factors including depression, which can be affected with education and intervention, as well as the diagnostic-related groups of heart failure, acute myocardial infarction and chronic obstructive pulmonary disease; 2) Event factors such as lack of primary care follow-up, poor education prior to discharge and previous readmission history within 30 days after discharge; and 3) Medication-related issues that are often attributed to medication discrepancies, unexplored adverse drug interactions, as well as medication noncompliance.

3. CONNECT TO A PATIENT-CENTERED MEDICAL HOME

Research shows that particular patients receiving care through a patient-centered medical home have fewer admissions and readmissions within 30 days after discharge from the hospital. Increased access to personal physicians with additional evening and weekend hours, patient self-management tools and ancillary services that integrate them into the primary care practice provide patients with additional benefits they may not be able to receive otherwise. Furthermore, evidence suggests patient-centered medical homes can decrease the cost of providing care to groups of patients by as much as five percent.

4. DEVISE A FINAL CHECKLIST BEFORE DISCHARGE

Ultimately, physicians should create a plan to monitor a patient's health after he or she has been released from their care. In-hospital case managers would be wise to address all areas mentioned throughout this article. Most importantly, a patient should not be released from care without a follow-up primary care appointment; high-risk patients should return within two to five days, and lower-risk patients within seven to 10 days after discharge. The medication checklist and medication reconciliation should be reviewed with the patient, preferably using clinical decision support software to prevent adverse drug events. Checklists should include a patient "teach-back" where a patient describes how he or she will continue the agreed-upon care at home. Physicians who take responsibility for their patients' care once they've left the hospital setting not only set precedence for future care models, but also greatly reduce any confusion the patient may have about his or her continued treatment plan.

In order to continue to provide the best services for patient care, hospitals should re-evaluate their care structures for improvement. These steps allow hospitals and physicians alike to adjust pre-existing structures without greatly impacting standing practices.

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▶DID YOU KNOW...

According to a May report released by the ***Centers for Medicare & Medicaid Services (CMS)***, preventable 30-day all-cause readmission rates for Medicare dropped to 17.5 percent in 2013 (compared to 18.5 percent in 2012), representing an eight percent reduction in the readmission rate since 2011.

Dealogic reports nearly $163 billion worth of healthcare deals have been proposed so far this year, up almost 50 percent from 2013 and 211 percent above the post-financial crisis low of $53 billion in 2012.

More than 400,000 people die every year in the U.S. due to preventable hospital errors, according to ***Leapfrog***.

According to the ***Robert Wood Johnson Foundation***, fewer than eight percent of Americans have long-term care insurance and it paid for less than 12 percent of $220 billion in long-term care costs in 2012.

While 93.9 percent of practices participating in new insurance plans have seen patients with Affordable Care Coverage, only 1.4 percent said that their patient population had increased significantly, 24.4 percent observed a slight increase and 56.4 percent reported no change, according to a survey conducted by the ***Medical Group Management Association***.

CMS's plan to expand the Medicare anti-fraud demonstration project, which mandates prior authorization for certain medical devices and equipment before the items are delivered or claims for payment are submitted, would save between $100 million and $740 million over the next decade, according to federal officials.

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IT'S TIME TO REVISIT HEALTHCARE NONPROFIT BOARD GOVERNANCE

By Steven Shill, BDO USA

HAVE YOU EVER WONDERED WHERE RESPONSIBILITY BEGINS AND ENDS FOR A BOARD MEMBER OF A NONPROFIT HEALTHCARE ORGANIZATION?

In today's healthcare environment, where change and unpredictability are the order of the day, this question has become increasingly important.

▶DESPITE A VARIETY OF RESOURCES, BAD HABITS CAN BE HARD TO BREAK

A seemingly endless supply of opinion and sites designed to provide healthcare organizations with guidelines on how to establish and maintain effective board governance exist, such as the National Council of Nonprofits and the Nonprofit Resource Center. Furthermore, this is a topic that has been discussed for years, preceding the Affordable Care Act (ACA) and the changing face of healthcare. Yet, despite such guidance, many nonprofit healthcare boards continue to fail to heed the good advice available to them, meaning the debate remains as relevant as ever.

Here are a few general thoughts on steps board members often struggle with on this front:

- Board members don't always take the time to understand what is being asked of them.
- They fail to ask enough questions initially, or throughout their tenure, and place too much trust in the few who purport to understand the issues.
- Domineering personalities can make compromise difficult.
- Team members possess poor communication skills.
- There is underwhelming support for meetings to discuss strategies, which can lead to a shortfall or weakness in the board's standing policies.
- Board members may lack appropriate focus, and may have difficulty balancing internal with external demands.

Some specific healthcare challenges include:

- Healthcare is a complex field, and board members may not fully understand these nuances.
- They may not understand the compliance and regulatory environment, including patient care.
- They often confuse the healthcare organization's mission with its business model.

▶WHAT ARE THE GENERAL POINTS TO REMEMBER?

While being recruited to serve on a board of a hospital or a health system may be an honor, the increased level of federal government emphasis on regulatory compliance, including the False Claims Act, places the onus on the board member not to take this "honor" lightly. Therefore, the board member has the legal duty of a fiduciary, which includes the duties of loyalty, care and obedience. It is vital to understand how these duties apply in the healthcare setting:

- **Duty of loyalty** — The healthcare organization or hospital must come first. There can be no conflicts of interest and no dualistic agendas.
- **Duty of care** — The board member of the healthcare organization must act in good faith by asking all the right questions, getting an independent expert's view, understanding all the laws and regulations impacting the organization and ensuring he or she is appropriately educated in areas where decisions are to be made.
- **Duty of obedience** — Board members have a responsibility to be faithful to the organization's stated mission and not to act or use its resources in incompatible ways or for questionable purposes.

▶WHAT ARE THE CONSEQUENCES OF FAILING TO FOLLOW THE AFOREMENTIONED DUTIES?

According to *Trustee* magazine, failing to comply could leave the board member or trustee with significant legal liability. The authors of the article provide guidelines for ways the board member can avoid this liability, such as establishing the appropriate polices, committees and performance metrics for board members, as well as reviewing organizational and external resources.

To learn more, check out some of the Nonprofit Standard blog's previous coverage of governance issues, as well as our guide on Effective Audit Committees. Additional resources to ensure nonprofit healthcare organizations achieve good board governance include the American Hospital Association's site for Healthcare Governance and this jointly authored publication by the Department of Health and Human Services Office of Inspector General and American Health Lawyers Association.

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UNCERTAINTY IN THE HEALTH INSURANCE MARKETPLACE CALLS FOR BETTER PRACTICES

By Lynn Marie Pepper, CRCE-I, The Rybar Group, Inc.

Have you ever thought about your point-of-service (POS) collection and where you rank among your peers? Does your POS collection equal at least three percent of your net revenue? Today's top performers are collecting 40 percent, and even small providers have the ability to collect between $200,000-$500,000 annually. In an ever-shifting health insurance marketplace, it is more critical than ever that providers learn from top performers when creating an effective POS collection program.

▶THE SHIFT IN FINANCIAL RESPONSIBILITY FACING PATIENTS

The new health insurance marketplace has created a significant shift in financial responsibility to the patient. It is anticipated that the new bronze and silver plans reflect patient responsibility of anywhere between 33 to 40 percent. Higher deductibles, copays and the growing number of the underinsured have created new challenges, as a higher percentage of net revenue is coming from patients. Further, many hospitals reported a decrease in patient volume during Q1 of this year, which is being attributed to the number of high-deductible health plans that discourage patients from seeking immediate healthcare.

While patients are paying more out-of-pocket costs, many newly insured patients entering the marketplace are unfamiliar with common insurance concepts, such as coinsurance, deductibles and in-network versus out-of-network options. Others are eligible for insurance via the marketplace, but have yet to register or may be unaware as to how to enroll. In some states, a patient's insurance card may indicate the plan was purchased through the marketplace, which means hospitals need to verify if the hospital or physician is in-network prior to the service being rendered.

▶AN UNCERTAIN ENVIRONMENT LEAVES QUESTIONS UNANSWERED

With the uncertainty of the marketplace premiums and the 90-day grace period issues, the carrier may say "valid coverage" even if the patient has not paid his/her premium. If the patient does not pay his/her premium, months two and/or three will default to self-pay. The question has been raised as to whether the provider may pay the premium. In November 2013, the Department of Health & Human Services (HHS) released a notice cautioning against third-party payment because it could skew the insurance risk pool and create an unlevel field in the marketplace. However, in some instances, payers may accept payments from third parties. CMS released some clarification on Feb. 7, 2014. They stated that if a private, not-for-profit foundation makes a payment for people who purchase insurance through the marketplace, they would expect that premium and any cost-sharing payments would cover the entire policy year. To add yet another layer to the already complicated and confusing payment structures and responsibilities when treating the uninsured, the IRS-issued Section 501(r) recently imposed new requirements on charitable 501(c)(3) hospitals. Yet some nonprofit hospitals remain unaware of these new requirements. Moreover, there is general misunderstanding of the various conditions, including the requirement to limit amounts charged for emergency or other medically necessary care to individuals eligible for assistance under the hospital's financial assistance[1].

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UNCERTAINTY IN THE HEALTH INSURANCE MARKETPLACE

▶THE IMPORTANCE OF COMMUNICATION

As a patient's cost-share responsibility increases, there will be greater demand for better financial communications, pricing and quality transparency.

According to an April 2014 TransUnion survey[2] involving more than 700 insured patients:

- Pre-treatment estimates of out-of-pocket costs would improve 75 percent of patients' ability to pay for healthcare;
- Nearly 56 percent of patients either rarely or never received an estimate of out-of-pocket costs before they received treatment; and
- Fifty-nine percent of patients said they have been surprised by the costs they were responsible for when receiving their final bill.

It clearly pays to work with patients, informing them of their financial responsibility and providing them with options available.

▶BEST PRACTICES DEMONSTRATED BY TOP-PERFORMING HOSPITALS

Healthcare leaders are instituting a number of useful approaches to create an effective POS collection program. A number of top-performing hospitals have instituted educational programs to simplify the process and educate their staff, while others have selectively trained staff, financial counselors and managers as certified application counselors (i.e., CACs or Navigators) to assist patients with their questions.

Some larger university hospitals are taking an aggressive and proactive approach, adding a team of financial counselors to take over POS collections in their emergency rooms. They are also finding success with the help and sophistication of today's software technology, which provides credit scoring and presumptive eligibility, and solidifies payment sources. Smaller hospitals are also providing financial counselor assistance and conducting POS collections in the emergency room, preparing estimates for outpatient walk-in laboratory/X-ray services and scheduled tests and procedures, with more than $235,000 in collections annually.

▶LESSONS LEARNED

Today, it is even more critical than ever to reach out to patients, implement best practices, learn from top performers and provide guidance for communicating with patients about their financial responsibility for health care. If you are collecting, improve your processes. If you are not collecting, now is the time to start. Identify processes, policy and procedures, create tools and provide scripting, upgrade technology, educate staff and the communities you serve, assess competencies, establish metrics, track and follow up. Above all, review the practices of your peers to help define what makes a POS collection program work.

1 http://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/New-Requirements-for-501(c)(3)-Hospitals-Under-the-Affordable-Care-Act

2 http://newsroom.transunion.com/press-releases/transunion-survey-finds-patients-willing-to-pay-mo-1104086#.U4T9mfldWmk

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PErspective in Healthcare

The outlook for investment in the healthcare industry continues to be positive but, overall, private equity investors are cautious about high valuations. This will likely continue to be a factor for investment in the healthcare industry looking into the second half of 2014.

The healthcare industry saw a decline in M&A activity in Q1 2014 with only 235 deals – a 4.9 percent decrease from Q1 2013 and a 4.5 percent decrease from Q4 2013, according to *Modern Healthcare*. That said, the deal value story is very different. M&A deal value for Q1 2014 was $48.9 billion, which vastly exceeded Q1 2013's $11 billion and also showed a jump from Q4 2013's $38.4 billion in deal value.

While appetite for investment in the healthcare industry remains high, fewer acquisition targets remain on the market, and competition for the remaining investment opportunities is increasing. Accordingly, those targets are drawing higher prices.

So how are investors approaching investment in the healthcare industry given these rising prices?

For some, it means looking to less visible targets within the healthcare industry lens. For example, workers' compensation insurance has seen an increase in private equity interest over the past few months, and smaller healthcare companies are also garnering attention from investors. Other funds are pursuing higher-priced deals but are also benefitting from easy access to financing in the healthcare industry. This, combined with a willingness by buyers and sellers to accept deals financed with a mixture of stock and cash, means that higher priced deals are easier to finance. And in some instances, price is not proving to be the deciding factor. Sellers know they can be "picky" about their investment partners, and are looking for "intangible factors" beyond dollars, such as cultural alignment and other benefits.

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

▶ Read more

MARK YOUR CALENDAR...

JUNE 2014

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

JULY 2014

July 14-16
Healthcare Analytics Symposium
Swissotel Chicago
Chicago, Ill.

July 15-17
Government Health Care Congress
Tysons Corner Marriott
Tysons Corner, Va.

July 17
2014 Senior Housing News Summit *
University Club of Chicago
Chicago, Ill.

July 20-22
Health Forum and the American Hospital Association Leadership Summit
Manchester Grand Hyatt
San Diego, Calif.

July 23-23
iHT2 Health IT Summit
Hyatt Regency Denver Tech Center
Denver, Colo.

AUGUST 2014

August 3-6
ASHE Annual Conference and Technical Exhibition
McCormick Place, Lakeside Center
Chicago, Ill.

August 3-6
AHRMM Annual Conference & Exhibition
Orlando World Center Marriott
Orlando, Fla.

SEPTEMBER 2014

September 8-9
World Congress Patient Engagement Summit
Hyatt Regency Boston
Boston, Mass.

September 20-24
World Medical Tourism & Global Healthcare Congress
Gaylord National Resort and Convention Center
Washington, D.C.

* Indicates that BDO representatives will be present at conference.

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- Integrated Delivery Systems
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- Physician Practices
- Preferred Provider Organizations (PPOs)
- Senior Housing, including CCRCs

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