

THE NEWSLETTER FROM THE BDO CENTER FOR HEALTHCARE EXCELLENCE & INNOVATION

BDO KNOWS HEALTHCARE



OPPORTUNITY IS RINGING: THE BUSINESS CASE FOR TELEHEALTH

By William Bithoney, M.D., FAAP, The BDO Center for Healthcare Excellence & Innovation

Hospitals and health systems have been relatively slow to embrace telehealth, concerned about the quality of care as well as legal and reimbursement issues. However, it is a force in healthcare that can no longer be denied.

The global market for telemedicine technologies was valued at \$17.8 billion in 2014, and is expected to grow at a compound annual growth rate of 18.4 percent through 2020, according to a [Research and Markets report](#). A [Mordor Intelligence report in August](#) said the global telemedicine market may top \$34 billion by the end of 2020, with North America accounting for more than 40 percent of the total. Whatever the ultimate size of the market, there is no doubt that the real opportunities are untapped.

As its acceptance grows among both patients and insurance plans, and the regulatory environment surrounding telehealth has improved, it may be time for hospital administrators to take a second look at where telehealth services may prove to be valuable.

ANSWERING THE CRY FOR IMPROVED ACCESS

Several market dynamics are driving up the demand for telehealth services. An aging population in the U.S. will lead to more patients facing transportation challenges, with elderly patients hindered by their ability to drive or by the ailments they face. On the other side of the coin, younger patients are highly accustomed to mobile devices and immediate access to everything, making them more comfortable with the idea of a remote diagnosis. A recent [Harris Poll survey](#) found

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TELEHEALTH

that 64 percent of American consumers say they are willing to have doctor visits via video telehealth.

As more patients become comfortable with the idea, video consultations between primary care doctors and patients will likely double over the next five years in the U.S., according to a [report from information and analytics firm IHS](#). Employers are increasingly interested in the benefits that telehealth services can provide as well. A recent [National Business Group on Health survey](#) found that 74 percent of large employers surveyed plan to offer telehealth to employees in states where it is legal during open enrollment season, up from 48 percent currently. Commercial payers are also jumping onboard. Earlier this year, UnitedHealthcare launched a national telemedicine-provider network, saying it will offer coverage for virtual doctor visits to 20 million beneficiaries by next year. Other major insurers, such as Aetna and Cigna, have also embraced telehealth.

The result: Telehealth companies are on a growth surge, with [Reuters reporting](#) that leaders like American Well experienced 1,100 percent year-over-year growth in 2014, and patient visits to Teladoc jumped from 127,000 in 2013 to 299,000 in 2014. Investors are intrigued by telehealth's promising future, as more entrants enter the field from different corners of the healthcare landscape. During the second quarter of 2015, telehealth companies had a record fundraising quarter hitting \$152 million in 18 deals, according to a [Mercom Capital Group report](#).

IMPROVED REGULATORY ENVIRONMENT

At the same time, the regulatory environment has generally become more supportive of telehealth services. As of this writing, nearly 30 states have enacted telemedicine parity laws, and parity legislation is active in a number of additional states. Progress is being made to enact further change. A [variety of bills were introduced in May on Capitol Hill](#) to expand federal support for telemedicine, followed by new legislation proposed in July by U.S. Representative Mike Thompson (D-CA) to

provide payment parity for an expanded list of telehealth services for Medicare beneficiaries, according to the American Telemedicine Association.

The Centers for Medicare & Medicaid Services (CMS) have been slowly coming around. In January, CMS published a new Chronic Care Management (CCM) code to allow physicians to bill for video consultations to a particular group of their Medicare patients remotely and between visits. Since then, [additional clarifications for the code have been proposed](#), including a requirement that the patient must already have an established relationship with the provider using the code, and that only one hospital can furnish and be paid for the services during the calendar month period.

The [American Medical Association](#) has slowly embraced change as well, advocating a telehealth policy that emphasizes in-state licensure and supports using telehealth in cases where a physician-patient relationship is already established and can help maintain a relationship, enhance follow-up care or manage chronic conditions.

MAKING THE BUSINESS CASE FOR HOSPITALS

Most health care leaders have already begun developing or implementing a telemedicine program, according to a [survey from law firm Foley & Lardner](#). Among those surveyed with active programs, 64 percent are offering remote patient monitoring services and 54 percent have real-time interaction capabilities.

With the ongoing shift toward value-based care, the combined consideration of financial investment paired with quality outcomes is of utmost concern to hospitals. The good news is that, financially, telehealth programs are more affordable today than they once were. Equipment has become less expensive, and technology like Skype has made videoconferencing much more accessible to everyone. The clinical case continues to be made, with evidence that telehealth can be just as clinically effective for treating some issues as in-person treatment. For example, a [recent RAND Corporation study](#) found

that patients treated for acute respiratory infection by physicians via telephone or video are as likely to be prescribed an antibiotic as those being treated face-to-face.

Where and how telehealth is best implemented may vary significantly from hospital to hospital, requiring an assessment of individual needs. Start with examining areas with significant staffing, outcomes or patient satisfaction issues. For example, are there particular areas where readmission rates run particularly high, and could telehealth be a part of the solution? Or, could telehealth help address challenges hiring certain physician specialists?

SOME POTENTIAL USES

Readmissions: Among the biggest considerations is how telehealth can help hospitals reduce readmissions, a key focus for securing reimbursements. Remote monitoring programs can be critical to the success of managing patients with chronic diseases, making communication more accessible or preventing complications that may arise after patients leave the hospital. For example, heart rate monitors can broadcast EKG results, enabling physicians to prescribe a course of treatment that might eliminate a return visit to the hospital. They can also help to reduce the length of time patients have to stay at the hospital, providing a cost-effective option for at-home monitoring.

Behavioral Health: Behavioral health is one area where telehealth may be particularly promising for hospitals. A simple Google search of "ER psychiatric patients" provides a wealth of headlines and evidence of the problems that psychiatric patients can impose on emergency rooms. Telehealth services can be used to reduce the major logjams that occur in some ERs by connecting psychiatric patients to the necessary proper care remotely to improve treatment. The [American Psychological Association](#) says that telehealth can be an effective treatment approach, pointing to a 2009 review of 148 peer-reviewed publications examining the use of videoconferencing to deliver patient interventions, which showed high patient satisfaction, moderate to high clinician satisfaction and positive clinical outcomes

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TELEHEALTH

(*Clinical Psychology: Science and Practice*, Vol. 16, No. 3).

Pathology and Radiology: Telehealth can also prove beneficial in other areas of the hospital such as pathology and radiology. Advancements in technology have made it possible to prepare a slide onsite at the hospital to send electronically to a pathologist. In the case of radiology, hospitals might consider using a licensed partner in another country like Australia, where they have specialists readily available in the middle of the night in the U.S. to read ER and ICU tests.

ICU: Telehealth can be an invaluable asset in areas where there might be a shortage of specialists on staff around the clock, such as board certified intensivists. Healthcare leaders such as the Mayo Clinic are using electronic Intensive Care Units (eICUs) to remotely monitor patients—finding value in the technology even as government reimbursement lags behind.

EMBRACING THE FUTURE

While telehealth has its limitations, the potential benefits are worthy of serious consideration by hospitals. When focused strategically on solving a problem area within the hospital and managed properly, telehealth can produce a long-term financial as well as clinical benefit. As pressure rises to find creative ways to take costs out of the healthcare delivery system, we'll likely be seeing increasingly innovative uses of telehealth.



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Perspective in HEALTHCARE



The field of telehealth—using telecommunications technology and electronic information to enhance the support and delivery of healthcare solutions, education and public health—is growing in popularity and is a promising area for private equity investments.

Startup incubator Rock Health puts 2014 funding for digital healthcare technology companies at over \$4.1 billion—a 125 percent year-on-year increase—and claims the pace has not slowed in 2015, with \$2.1 billion raised in the first half of the year, according to the Association of Corporate Counsel (ACC). As incubators and accelerators in the field proliferate, and as telehealth technology use increases in the healthcare industry, PE and VC interest will continue to grow, the [ACC writes](#).

Indeed, 2015 has seen some significant deal activity so far. For example, PE firm Bedford Funding's HealthTech Fund, Bedford Funding II, recently made a \$50 million growth equity investment in Florida-based virtual medical consultations provider MDLIVE. And Columbus, Ohio-based telehealth language interpretation services provider Language Access Network recently announced a partnership with Kayne Partners, the growth PE arm of Kayne Anderson Capital Advisors.

While fundraising activity has been strong so far this year, the real growth may be yet to come, thanks in part to a nationwide rise in payment parity laws and regulations. Under commercial payment statutes now in force in 29 states plus the District of Columbia, commercial health plans must provide equal coverage to medical services provided via telehealth and in person.

Such laws have seen a rapid rise over the last few years, and at least half a dozen other states have similar bills currently in development, according to industry newsletter [mHealth Intelligence](#).

Growth in the sector is also being boosted by the Centers for Medicare and Medicaid Services (CMS), which has awarded states more than \$960 million for healthcare systems via its State Innovation Models (SIM) initiative, according to legal newsletter [Law360](#). Colorado, for example, was granted \$65 million to improve access to behavioral healthcare, by integrating primary care and behavioral healthcare payment and data systems, [Healthcare Dive](#) reports. Such grants, aimed at helping states develop innovative healthcare payment and delivery solutions, are turning more heads toward telehealth services, which can offer a cost-effective way to improve patient access to the care they need. Initiatives like these are driving up demand for telehealth, creating more health tech sector opportunities for PE firms.

We are nearing the "end of the beginning" of this process. Telehealth services are neatly aligned with major healthcare transformation initiatives, including the need to improve post-acute care and urgent care models, and driving patients to the right care in the right setting to drive down costs. The rise of payment parity laws, SIM grants and the general increasing use of digital technology to deliver and improve services in the healthcare sector are creating an environment that is ripe for PE investment.

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

THE CADILLAC TAX: A Catalyst For Inevitable Change?

By Patrick Pilch, CPA, MBA, The BDO Center for Healthcare Excellence & Innovation



The Affordable Care Act's (ACA) high-cost plan tax—dubbed the “Cadillac tax”—has been the center of heated debate.

Its intention of pushing large employers toward more cost-effective plans by taxing health care benefits above a certain threshold invites a number of challenges to which critics have been calling attention. One of the biggest pain points for employers: Despite their best efforts, healthcare plan costs continue to rise annually. Although the excise tax doesn't kick in until 2018, it is already forcing organizations to take measures to reduce health plan costs. Momentum may be building (as of this writing) to [repeal the Cadillac tax](#), but regardless of what happens, the issue shines a light on the need for a dramatic new approach to managing an organization's healthcare risks.

WHERE ARE WE NOW?

As it is currently written, the Cadillac tax places a 40 percent, non-deductible excise tax on health benefit plans that exceed a certain threshold beginning in 2018. The

threshold for 2018 is \$10,200 for individual coverage plans and \$27,500 for all other plans, and then it increases annually with inflation. The revenue generated from the tax, which the [Congressional Budget Office puts at around \\$87 billion](#) over the next decade, is central to funding the ACA's subsidized plans. However, there may be movement with regard to its repeal in the budgetary reconciliation process.

The IRS has been working to bring clarity to a number of issues that lie within the regulatory language. In February 2015, the IRS issued [Notice 2015-16](#) to address the definition of applicable coverage, how to determine its costs and how dollar limits apply, and other issues. It followed with [Notice 2015-52](#) in July 2015, which explored issues including how to identify the taxpayers liable for the tax, making adjustments for age and gender, and other concerns about the cost of applicable coverage. The guidance and submission process suggest that there is still much work to be done before the details are finalized.

Critics are rallying around two major challenges that the excise tax presents for

organizations. First is the notion that the tax targets “overly generous” high cost plans that are offered by large employers. The reality is that some organizations employ individuals who have more expensive health issues that drive up the cost curve, regardless of the plan changes they are making. Unions have also been very vocal opponents of the tax, as union members often receive generous health benefits in lieu of wage hikes that can be more difficult to secure. It was a [major focus of the UAW's contract negotiations](#) in August and September with several large automakers. Other labor unions are considering strategies to address this as well.

The second argument centers on the problem of healthcare costs that continue to rise. A [recent Kaiser Family Foundation analysis](#) estimates that 42 percent of employers will have plans in which costs will exceed the tax's threshold for some or all employees by 2028. Already in 2018, it's estimated that 46 percent of large companies—defined as organizations with more than 200 employees—would have to pay the tax that first year, in addition to 25 percent of small firms. Furthermore, the Kaiser report notes that 100 percent of employers have plans that will eventually be impacted by the tax, assuming that health plan premiums continue to grow faster than inflation, which has been the case. The dollar level triggering the Cadillac tax increases only in relation to the Consumer Price Index, which grows much slower than medical costs.

Another [survey from the National Business Group on Health](#) (NBGH) illustrates the challenge of rising healthcare costs for large employers. It found that employers are projecting a 6 percent increase in healthcare benefits costs in 2016, but intend to keep increases to 5 percent by making plan changes such as increasing cost-sharing provisions or adopting consumer-directed health plans. Without additional changes to control costs, nearly half say at least one of their health plans will trigger the Cadillac tax.

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THE CADILLAC TAX

What does this mean for employers? Regardless of what happens with the Cadillac tax, organizations must find a way to better stratify their healthcare risks. They must elevate their actions to better manage the risks that are driving up costs, instead of restricting their focus to plan changes.

NEW APPROACHES TO AN OLD PROBLEM

Employers are starting to think differently. New approaches to managing healthcare risks are being tested in the marketplace; some of them have been around for several years and are now starting to gain more traction. Among them:

- ▶ **Developing, or partnering with, private exchanges.** Only 3 percent of large employers will have moved employees to a private exchange by 2016, but 24 percent are considering it for the future, according to the aforementioned NBGH survey. Retirees are a particularly attractive target for private exchanges, with 24 percent of large employers offering them coverage through a private exchange, up from 10 percent in 2013. Private exchanges often enable companies to offer their employees more health insurance options. Still, many employers are keeping their distance, either because they are waiting for proof of the potential cost savings and value of these plans, or because they know little about it. Only 36 percent of HR professionals [surveyed by the Society of Human Resource Management](#) said they are aware of any existing private health insurance exchange.
- ▶ **Establishing on-site medical clinics.** More organizations are considering the benefits of bringing healthcare services directly to employees, hoping the convenience of having a clinic on-site not only improves productivity but ultimately improves their health. A [recent Mercer survey](#) found that most employers offering on-site clinics are uncertain how the Cadillac tax will impact this trend: 15 percent believe their clinics will hurt them in terms of the excise tax calculation, while 28 percent believe it won't have an impact and another 46 percent say they

don't know. However, most believe the programs are a success, with 63 percent reporting a successful reduction in lost work days and 58 percent reporting improvements in helping members control chronic conditions.

- ▶ **Creating bundled payment programs.** Cleveland Clinic was a pioneer in this area, when it started a bundled payment agreement with Lowe's in 2010 to provide high-value services to covered employees while keeping costs down. It has extended the concept since then, creating [Cleveland Clinic's Program for Advanced Medical Care \(PAMC\)](#), through which it partners with self-insured companies to create innovative programs that include bundled pricing. For example, its program with Wal-Mart gives employees access to Cleveland Clinic's cardiac surgery expertise with no out-of-pocket costs. These kinds of arrangements can yield cost-saving benefits for all parties involved and lead to improved outcomes for patients, while directing a steady stream of business to providers. However, the process is far from static and requires consistent, diligent monitoring.
- ▶ **Redefining the entire system of care.** Pushing the envelope on a much grander scale, Intel has changed its entire approach to healthcare through its Healthcare Marketplace Collaborative. An article in the [July-August issue of Harvard Business Review](#) details the approach, but essentially, Intel used its purchasing power to have a seat at the table with payers and providers to jointly design systemic changes that could improve the health of its employees and reduce costs. Teaming up with a local health system in Seattle and its health plan administrator, Cigna, the pilot program focused on treating and screening for six medical conditions and reduced the direct costs of treating three of the conditions between 24 percent to 49 percent over five years. While this approach is certainly not for the faint of heart, it demonstrates how big employers have a prime opportunity to raise the stakes in how they approach healthcare risks.

STEPPING OVER THE LEDGE

The Cadillac tax is more of a side note to the thornier, lingering problem with healthcare costs and the implicit social contract between employers and employees. Tax matters aside, employers are staring at annual cost increases. [The Kaiser Family Foundation/Health Research & Education Trust 2015 Employer Health Benefits Survey](#) provides evidence of increased costs for employers and employees. According to the survey, annual health insurance premiums increased 61 percent for employers for the period between 2005 and 2015. Employees saw an even steeper increase in their contribution to healthcare, at 83 percent. These increases occurred during a period of cumulative inflation of approximately 22 percent. The upheaval in the healthcare marketplace is changing everything. And that means it's time for employers to do a serious examination of how to better manage their healthcare risks. A few key questions to consider:

1. Have you assessed the total cost of employee benefits, factoring in the cost of recruitment and retention?
2. Have you assessed the quality of care and financial costs of the providers in your benefit plans?
3. What is your corporate philosophy with regard to risk management and the social contract with your employees?
4. Do you know the providers in your employees' markets, and are you capable of assessing their ability to serve your employees?
5. Have you calculated the potential impact of the Cadillac tax and compared it to taking on an alternative approach to your current plan structure? Is your organization ready to take on that risk?

A version of this article first appeared on the [BDO Knows Healthcare blog](#).



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501(R) – WHAT SHOULD YOU BE DOING AS THE DEADLINE APPROACHES?

By Laura Kalick, JD and LL.M. in Tax, The BDO Center for Healthcare Excellence & Innovation



If you are in a leadership role at a 501(c)(3) hospital, you know about section 501(r) of the Internal Revenue Code. However, do you know what you should be doing to avoid having the hospital's tax-exempt status revoked—the severest sanction—or about the lesser but more likely consequences?

To avoid penalty, when a hospital discloses on Form 990 that it was not in compliance, it's vital that corrections are adequate and timely.

There has been significant discussion this year about [new provisions outlined in Section 501\(r\)](#) to which nonprofit hospitals must adhere in order to retain their tax-exempt status. The key components are detailed in a [newsletter article](#) I wrote earlier this year. Less frequently discussed are the consequences of being non-compliant, whether intentional or unintentional, and the needed corrections.

First, let's address the unintentional.

Compliance mistakes happen. They can be as simple as having a website down,

preventing your community health needs assessment (CHNA) from being fully accessible to the public. These are things that can be easily and quickly corrected. As long as they are discovered and addressed in a timely manner, trouble can be avoided.

Then, there is intentional non-compliance, defined as "willful and egregious." Essentially, this involves blatant disregard for any of the 501(r) provisions and/or not fixing problems that surface. A hospital's tax-exempt status would clearly be at stake as a result of these failures.

More often, compliance problems fall into a gray area, or occur without hospitals being aware they are at risk. These include issues such as:

- ▶ Joint ventures and other alliances existing between nonprofit hospitals and for-profit entities, blurring the line on how to stay compliant;
- ▶ Hospitals doing community benefit reports for state reporting requirements and assuming that the same compliance rules apply under 501(r);
- ▶ Failure to update CHNAs after first issuance to demonstrate progress and/or the development of enhanced programs to create meaningful improvements to outcomes; or

- ▶ Overcharging a patient who was eligible for the hospital's Financial Assistance Policy (FAP).

Two of the best ways to avoid penalties as the result of engaging in suspect or ambiguous activities in this gray zone are to: (a) show corrective action for an issue, once discovered; and (b) to disclose any mistakes that were made on Form 990. For example, in the case of a FAP-eligible patient who was overcharged, hospitals must disclose the error and demonstrate that they have corrected the issue by refunding the charge as soon as the problem was discovered.

The IRS has published a safe harbor revenue procedure ([Rev. Proc. 2015-21](#)), which, if followed, would allow hospitals' unintentional errors to not be considered failures, excusing them for the purposes of section 501(r).

MAKING CORRECTIONS

Correction, according to the IRS's revenue procedure, involves four elements:

- 1. Restoration:** A FAP-eligible person, who paid an amount greater than that generally billed to other patients, must be reimbursed the overcharge. It also doesn't matter when the overpayment occurred; the hospital must go back to a prior tax year, even if that year is closed for tax purposes.
- 2. Reasonable and Appropriate:** The restoration must be reasonable and appropriate; there may be more than one method that will be deemed reasonable and appropriate.
- 3. Timing:** The correction should be made promptly after it is discovered.
- 4. Implementation of safeguards:** The hospital must implement practices and procedures so that the error does not occur again. For example, hospitals that have failed to adopt a FAP possessing all required elements may correct that by adopting a compliant FAP and then widely

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501(R)

publicizing it. A hospital that has not widely publicized the FAP via a website can correct that error by putting the FAP on the web and sending out an email blast to all patients whose addresses the hospital has on record.

DISCLOSURE

If a hospital has made some inadvertent errors, it must disclose those errors on its Form 990, which, of course, is subject to public disclosure. The hospital must:

- ▶ Describe the type of failure, the facility where the failure occurred, the dates of the failure and its discovery, the number of occurrences, how many individuals it affected and estimates of the dollar amounts involved.
- ▶ Describe the correction, including the method of correction, the date of correction and how affected individuals were restored.
- ▶ Describe the practices or procedures implemented to minimize the likelihood of the failure occurring again.

If a hospital is notified by the IRS that it is going to be examined, it may only use the safe harbor provisions of the revenue procedure, if, at the time of notification:

- ▶ The hospital has corrected or is in the process of correcting the error; and
- ▶ If the due date for Form 990 (including extensions) has already passed, the hospital has already disclosed the failure on Form 990 as outlined above.

The consequences of non-compliance can be significant and possibly disastrous if an organization's tax-exempt status is revoked. To minimize the risks, nonprofit hospitals must examine their compliance procedures now to identify where there may be gaps and quickly address their mistakes and oversights.

Deadlines are approaching, especially if your hospital's year end is Dec. 31. If this is the case, Jan. 1, 2016, is the date set for full compliance with section 501(r). The IRS is reviewing every tax-exempt hospital every three years for compliance with these rules.

It is easy for the IRS to take a quick glance at a hospital's website to determine if an examination should be opened. Rather than risking the loss of tax-exempt status or the bad publicity of outlining errors on Form 990, hospitals might consider a "gap" analysis, i.e., where the hospital is now, and where it needs to be in order to become compliant. Some actions hospitals can take now to be prepared include:

- ▶ Putting together a team that includes inside and outside financial and legal personnel to analyze existing policies, websites, emergency and admission areas, billing statements, and certain joint venture agreements and contracts.
- ▶ Preparing policies that are consistent with regulations and having them adopted by the governing body.
- ▶ Preparing a FAP checklist covering requirements such as plain language summaries in required languages, eligibility criteria, application, documentation of amounts charged and a list of all the providers that are and are not subject to the FAP.
- ▶ Preparing discounts in accordance with amounts generally billed.
- ▶ Reviewing collection actions and modifying where needed.
- ▶ Posting policies to websites and appropriate public places and making them known to the necessary groups.

After a good program is in place, make sure that personnel are educated as to their responsibilities and whom to ask if they have questions. As long as a hospital takes the proper steps to recover after a mistake, it should be able to avoid penalty by coming into compliance. And remember, when it comes to tax matters, documentation is key!

A version of this article first appeared in [the BDO Knows Healthcare blog](#).



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**DID YOU KNOW...**

According to the *Kaiser Family Foundation/Health Research & Education Trust 2015 Employer Health Benefits Survey*, the average health plan premiums for both single and family coverage rose 4 percent to \$17,545 in 2015, extending a decade-long trend of relatively moderate increases.

Accenture reports that by 2018, the volume at which health providers buy non-acute-care facilities such as clinics or physician practices will increase to reach 84 percent of the total provider acquisition volume, up from 74 percent today.

Telemedicine services will be offered in health plans sponsored by 74 percent of large employers during the next year in states where it is legal, according to a survey released by the *National Business Group on Health*.

Under the Cadillac Tax, employers will pay a 40 percent tax on costs of health plans that are above \$10,200 per individual and \$27,500 for family coverage starting in 2018, according to *Forbes*.

The Department of Health and Human Services estimates that by 2020, nearly 32 million individuals will gain access to behavioral health coverage for the first time via Medicaid expansion under the Affordable Care Act.

Healthcare M&A activity in the first half of 2015 reached a record high of \$346.7 billion, according to *Dealogic*.

BUILDING A SUSTAINABLE MEASUREMENT STRATEGY FOR VALUE-BASED PAYMENTS

The BDO Center for Healthcare Excellence & Innovation and Rivkin Radler have been exploring the rise of quality data as a reimbursement benchmark in this three-part series. In this newsletter, we will focus on the implications for measurement strategies.

By Patrick Pilch, CPA, MBA, The BDO Center for Healthcare Excellence & Innovation



The transition from payment for work units to payment for the value delivered by healthcare services is taking hold, with government-backed innovation grants and investors funding efforts to disrupt the status quo, lower costs and improve care.

One of the keys to success—and key struggles—for healthcare providers in this transition is proving the value of the services and benefits they delivered. For providers to be paid, and to determine the level of payment, they must be able to measure the clinical outcomes that define this value. These metrics are also becoming more critical to merger and acquisition activities: Healthcare provider valuations will increasingly be based not only on traditional valuation methodologies, but also on the quality of the clinical data and measurement methods themselves.

MEASUREMENT MUST CHANGE WITH THE TIMES

To better understand where future measurement efforts must focus, it's important to examine the foundational shift underway in the U.S. healthcare system. The fragmented payment system has encouraged fragmented care. Hospitals, physicians, skilled nursing facilities, ancillary services, home health agencies and other providers have traditionally been paid based upon their activities (e.g., cases, visits, procedures). In some instances, payments are counterintuitive and siloed by provider type with no reward for coordination and collaboration around the patient.

The system is now moving away from a facility-centric model toward a more patient-centric approach. This fundamental shift will be as dramatic as that seen in the music industry, in which changing operating and distribution models combined with new technologies to shift music consumption from single-song and long-playing records to downloads and subscription-based models.

The shift to value-based payment (VBP) is requiring a new perspective on measurement. Current thinking regarding value-based payment among many hospital providers often is based upon their own perceptions and in relationship to their understanding of market conditions. Hospitals, physicians, payers and other providers have been investing significantly in analytics, people, systems, applications and studies, as the foundation of reimbursement shifts and accelerates the overall declines in payment.

Meaningful and relevant measurement begins and ends with an alignment of the future-state goals of value-based payment, and an understanding of what is important when changing behavior among providers, leaders, physicians, financial and clinical staff, and patients.

ESTABLISHING A MEASUREMENT FRAMEWORK

Where does one begin? There are several critical questions to address in order to build the proper measurement platform:

- ▶ **How is care currently measured and reported and what about it is relevant?** A baseline must be established by conducting an inward assessment of the organization in the context of what is needed to report to payers, regulators, clinicians, and financial and operations teams. While there are existing quality measures that have been established and proven, such as readmission measures, we will see how additional measures of quality need to be developed, identified and understood.
- ▶ **Is your organization ready to take on additional risk?** That's a broad question; most providers we talk to are open to taking on risk, but say they need guidance on how best to do that, given their organization and market. Does the organization have both the intellect and the will to understand and change?
- ▶ **What is your current governance structure, and does it need to be modified?** What is leadership's perspective on moving to value-based payment? Checking the box won't change behavior. Leadership must be deeply committed to repositioning the organization in order to change behavior, operations, skill sets and care models.
- ▶ **Who are the change leaders in your organization?** Are there physicians and clinicians who have primary leadership roles in the organization and who can drive? Are they viewed as partners or employees? What does the organizational team provide at the manager level? Are there change leaders on the front line who are motivated by improving

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VALUE-BASED PAYMENTS

performance? Measurable progress requires engagement. It is even more critical to assess and determine that the right medical leadership and staff have the right capabilities to change the operating model and position the organization to take on more risk efficiently.

- ▶ **How well does your organization know its true cost of care?** Providers cannot effectively price a bundled payment, one VBP option, unless they understand the true cost of services required to treat a given condition across an episode of care, from pre-surgical to acute to post-acute.
- ▶ **How are partner providers assessed and measured?** In extension of the above, the ability to measure the quality of each provider throughout the episode of care will increasingly drive decision making, affecting both reimbursement and the quality of care for patients. For example, selecting the right post-acute provider can no longer be based only upon cost, convenience or relationships—quality clinical outcomes as defined by such entities as the CMS Five-Star Quality Rating System must also be considered.

As Atul Gawande writes in *The Checklist Manifesto: How to Get Things Right*, "the volume and complexity of what we know has exceeded our individual ability to deliver its benefits correctly, safely or reliably." Yet the industry must realign to do just that. Measurement is foundational—what you measure and how you measure.

Transitioning to VBP will be a long journey, but providers must start now by conducting a thorough assessment to guide the work that lies ahead. Establishing a solid measurement strategy is a difficult, but necessary process to set the right tone for change within organizations.



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THE ACCOUNTING PITFALLS OF NEW HEALTHCARE REIMBURSEMENT MODELS

By John Barry and Nanda Gopal

In the United States today, it seems that innovation and change in healthcare business models are being outpaced only by the innovation and change in the underlying science.

The passage of the Patient Protection and Affordable Care Act (ACA) not only expanded healthcare coverage for much of the uninsured population in the U.S. but also put into place a myriad of changes to traditional healthcare reimbursement models. While the new models have their benefits, organizations should be aware of potential revenue recognition accounting issues they may face when entering into new arrangements, which could prove to be a pitfall.

TRADITIONAL VERSUS NEW REIMBURSEMENT MODELS

Traditionally, Centers for Medicare and Medicaid Services (CMS) has used a fee-for-service model whereby payments were made to healthcare providers for the individual healthcare treatments they provided to a program beneficiary. Even though a patient may only have a single episode of care, payments are made to each of the providers involved in treating the patient during that episode. Critics of a fee-for-service system argue that it misaligns the incentives for providers by rewarding them for quantity of services provided, rather than quality of care. The other traditional method of reimbursement is through a capitation model, in which healthcare providers receive a monthly fixed fee for every beneficiary covered (per member, per month payment) for all healthcare services provided to beneficiaries that month. The provider is incentivized to be more efficient as the payment they receive is fixed, so more frequent visits and higher costs directly impact the provider's net profits. Critics of a capitation system argue that it sacrifices patient care for efficiency, as providers will

treat the patient as inexpensively as possible. The CMS Innovation Center is currently testing several payment models designed to realign incentives for providers, thereby improving both the delivery and cost of care.

One of the initiatives brought about by the CMS Innovation Center is the Bundled Payments for Care Improvement (BPCI) initiative, which "bundles" all of the payments for multiple services provided to a patient during a single episode of care. Healthcare organizations enter into payment arrangements where financial and performance accountability is shared among all providers for the entire episode. The goal of BPCI is to have a more coordinated approach to care that will lead to a higher quality of healthcare at a lower overall cost, as providers succeed by coordinating with each other to contain costs and deliver healthcare more efficiently.

The BPCI initiative has four models that vary in scope, provider type, duration and retrospective versus prospective reimbursement:

- ▶ **The episode of care for Model 1** is the acute inpatient stay at a hospital, which is paid based on rates established under the Inpatient Prospective Payment System.
- ▶ **The episode in Model 2** starts with the inpatient stay at the acute hospital but also includes all related services up to 90 days after discharge.
- ▶ **The episode in Model 3** is triggered by the acute hospital stay but begins at the initiation of post-acute care at a skilled nursing or other long-term care facility. Both Models 2 and 3 use a retrospective arrangement where actual expenditures are reconciled against a target price for the episode of care. Under these retrospective payment models, Medicare makes fee-for-service payments as services are performed and then the total expenditures

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NEW HEALTHCARE REIMBURSEMENT MODELS

amount for the episode is later reconciled against a bundled payment amount (the target price) determined by CMS. If the total amount is less than the target price, the providers share in the savings with CMS via a bonus, and if the total amount is more than the target price, providers are then charged a recoupment amount.

- ▶ **The episode in Model 4** is the acute hospital stay and includes all services provided by the hospital, physicians, etc. during the entire stay. Physicians and other practitioners submit a “no-pay” claim to Medicare and are instead paid by the hospital out of the bundled payment.

ACCOUNTING IMPLICATIONS FOR THE MOST POPULAR BPCI MODELS

Models 2 and 3 represent the overwhelming majority of participants in the BPCI initiative, so the accounting issues involved in those models are discussed below.

Under Models 2 and 3, reimbursements are routed through a “convener,” which is an organization responsible for coordinating the patient’s care and reconciling the reimbursements to the bundled payment. Both the convener and providers will have contracts with each other and CMS. The convener will assign a principal accountable practitioner (PAP), who is responsible for the overall coordination of the episode of care. If total reimbursements are under the

target price, the PAP is eligible to share in any savings with the other providers via a gainsharing bonus. Gainsharing is typically prohibited by Medicare’s fraud and abuse statutes, but under BPCI, physicians are eligible to receive bonuses of up to 50 percent of the providers’ non-discounted Medicare fee schedule payment rates, which equates to a maximum reimbursement of 150 percent of the standard schedule rates. Coordination and cost saving among all providers is required to qualify for bonus payments.

Revenue recognition under these bundled payment models poses some interesting considerations. While the scope of the healthcare subtopic of Accounting Standards Codification (ASC) 954, “Health Care Entities, Revenue Recognition,” includes patient service revenue through fee-for-service arrangements and premium revenue from capitation arrangements, it does not address shared savings/loss arrangements. In other words, the healthcare accounting revenue recognition standard does not specifically address revenue earned that is not directly tied to a patient. Therefore, organizations need to look to the broader revenue recognition standards for guidance, i.e., the four criteria for revenue recognition: persuasive evidence of an arrangement, delivery has occurred or services have been rendered, fixed or determinable selling price and reasonable assurance of collectibility.

The first criterion, evidence of the arrangement, would appear to be easily

met, as there will be contracts in place; however, there are multiple contracts that are executed between the provider and CMS, between the provider and convener, and between the convener and CMS. Should these contracts be viewed separately, or should they be combined under a singular arrangement?

The criteria of delivery and fixed price offer some particularly tough challenges. As for delivery, the consideration should be the timing of when the delivery occurred. Was the delivery after the single provider performed its particular service, or did every provider have to wait until the complete episode of care was completed? There is also the question of whether the bundled payment constitutes a multiple element arrangement—which would mean the revenue recognition would fall under the multiple element guidance. In regards to the fixed or determinable selling price criterion and the gainsharing aspect of these arrangements, the question is, when can the organization recognize the revenue from the gain? Would it be when the service was performed (if the organization was able to estimate the gainsharing), or must recognition of the gain wait until final settlement? On the flip side, if it is projected that there will be a loss or recoupment, when should that loss be recognized? The collectibility criterion should be generally met, since CMS is the payor.

The new and innovative changes in healthcare delivery and reimbursement will likely lead to improvements in patient care, but the environment is not without its challenges, particularly when it comes to accounting for these payments. While the accounting should not ultimately drive business decisions, it is important to understand the accounting considerations and implications of these arrangements to keep stakeholders informed and avoid surprises.



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December 2-3

Forbes Healthcare Summit 2015

Lincoln Center
New York City

December 6-9

27th Annual National Forum on Quality Improvement in Health Care

Orlando World Center Marriott Resort & Convention Center
Orlando

December 14-16

Treatment Center Investment & Valuation Retreat

Omni Scottsdale Resort & Spa at Montelucia
Scottsdale, Ariz.

JANUARY 2016

January 22-25

ACPE's 2015 Winter Institute

Miami Marriott Biscayne Bay
Miami

January 27-28

The 7th Annual Leadership Summit on Readmissions

Hilton Atlanta Airport
Atlanta

January 27-28

2nd Annual ACO Population Health Management Summit

Hilton Atlanta Airport
Atlanta

January 27-28

4th Annual Telehealth and Remote Patient Monitoring Summit

Hilton Atlanta Airport
Atlanta

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