

THE NEWSLETTER FROM THE BDO CENTER FOR HEALTHCARE EXCELLENCE & INNOVATION

BDO KNOWS HEALTHCARE



THE URGE TO MERGE IN HEALTHCARE: THIS TIME, WILL IT BE DIFFERENT?

By Patrick Pilch, CPA, MBA, The BDO Center for Healthcare Excellence and Innovation and Scott Gottlieb, MD, American Enterprise Institute Fellow

THERE'S A FLURRY OF TAKEOVER TRANSACTIONS SWEEPING ACROSS THE HEALTHCARE SPACE.

The sector's key constituents are all seeking to grow in response to the confluence of market pressures set in motion by the Affordable Care Act.

Hospitals are merging and buying out providers. Doctors are consolidating into multi-specialty groups. Insurers are looking to link up and also acquire physicians.

Everywhere you turn, there's an urge to merge in healthcare.

In many respects, it's the 1990s all over again.

More than 105 hospital mergers occurred in 2012, up from about 50 to 60 annually from 2005 through 2007, according to a January report in the New England Journal of Medicine. That's still almost half the number of M&A transactions undertaken during the peak years in the late 1990s. (In 1997 alone there were 184¹ hospital M&A transactions.)² But the trend is building.

The number of doctors employed by hospitals grew by 32 percent between 2000 and 2010, according to a 2012 survey by the American Hospital Association. By 2013, the majority of primary care physicians were employees instead of owners, according to a

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THE URGE TO MERGE IN HEALTHCARE

survey conducted by the American Medical Association. Similarly, almost 63 percent of pediatricians and 60 percent of family practice physicians were either employees or independent contractors.³

The 1990s is the last time we saw this level of merger and acquisition activity. The average rate of hospital mergers doubled from 12 per year in the mid-1980s to 24 percent in the early 1990s, and then shot upward from there.

Declining Medicare reimbursement introduced with the Prospective Payment System, the advent of managed care, sweeping healthcare reform, along with a drop in demand for hospital beds (as more medical services shifted to the outpatient setting) all coalesced to spark a consolidation wave.

But a lot of those mergers also broke apart shortly after they were consummated. So why will today's consolidation wave end any differently?

Mergers failed in the 1990s for a host of reasons, not least of which were the changes in the commercial and policy environment that altered reimbursement expectations.

A backlash to managed care constrained the capitated contracting that justified consolidation. Reimbursement cuts made owning doctors less profitable. Most of all, the risk that providers were taking, under these capitated contracts, turned out to be poorly measured and providers lost money as a result.

Growth achieved through consolidation was supposed to enable providers to engage in global contracts. Providers took on the risk of caring for large patient populations, expecting to profit off of some of the savings realized once providers had an economic imperative to focus on cost and efficiency.

By the late 1990s, about one-third of physicians had contracts that paid them capitated rates for taking care of large patient groups. The money earned from these capitated contracts accounted for 21 percent of their total revenue.

But in the end, measuring the risk of these arrangements (and properly pricing the contracts) wasn't easy. Many newly big provider groups lost a lot of money. Numerous mergers were eventually unwound.

Will this time around be different?

Many in the industry say that hospitals and practice management companies overpaid for the doctor practices they acquired in the 1990s. Physician productivity also fell after these acquisitions, in part because reimbursement schemes didn't take into account changing practice patterns. These same mistakes, industry participants argue, won't be repeated.⁴

But chief among other factors is that, in the 1990s, the acquirers didn't have the tools (or data) to properly measure the risk that they were taking on through these global contracts. Practice management companies were supposed to add this layer of sophistication. But that actuarial expertise was never adequately adopted and hospitals didn't have ready access to the actuarial tools that were required.

Data on patient risk is now far more accessible, making it easier for providers to price capitated contracts. The tools for crunching these data sets are also readily available. And the actuarial skills required to conduct these analytics are more widely distributed across industry constituents and no longer the sole province of insurers.

Today, if a local hospital sees a lot of patients from a few of the community's large employers, the hospital can compute the costs of approaching those employers directly and signing global agreements with these self-insured businesses. Under Medicare, the data is generally even more readily available for conducting similar analyses.

But consolidating hospitals and provider groups must make the requisite investments to engage in these necessary analyses. In fact, this requirement should be a primary driver of today's M&A deals. And there should be a vibrant market for entrepreneurial startups that cater to these needs.

As of yet, neither seems to have taken hold.

This time, things should be different. The market forces that have set in motion the current consolidation wave are hardly perched to reverse. Principal among these is a preponderance of capitated contracts that shift financial risk to providers. Whether it's bundled payments, shared savings arrangements, or an alphabet soup of other schemes, capitation will be the dominant feature in contracting. In order to make these arrangements successful, accountants, actuaries and physicians must work together.

But success also depends on learning from some of the flaws that stymied the last wave of mergers. This time, the urge to merge needs to be coupled with some sober thought around how providers intend to measure and understand the risk they're taking on through these new arrangements, and how they plan to price it.

1 http://www.usc.edu/schools/price/research/healthresearch/images/pdf_reportpapers/Market%20power%20and%20hospital%20pricing-are%20nonprofits%20different.pdf

2 <http://www.the-american-interest.com/blog/2013/08/13/hospital-mergers-heat-up-nationwide/>

3 <http://www.advisory.com/daily-briefing/2013/09/20/as-hospitals-ramp-up-hiring-one-in-two-doctors-remains-self-employed>

4 <http://www.modernhealthcare.com/article/20140222/MAGAZINE/302229986>

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BETWEEN A RAC AND A HARD PLACE – REDUCING THE AUDIT PRESSURE

By William Bithoney, M.D., FAAP, and Venson Wallin, CPA, The BDO Center for Healthcare Excellence and Innovation



In August 2014, the Centers for Medicare & Medicaid (CMS) announced the Recovery Audit Contractor (RAC) program would resume claim reviews on a limited basis after the current contract lapsed in June. The purpose of the RAC program was, and remains, to identify and correct improper Medicare payments made by providers. In the federal government's fiscal year 2013, Medicare Recovery Audit Contractors recouped \$3.67 billion in overpayments – the greatest number in a single year since the program's inception four years ago.

However, despite the program's mission to prevent fraud, healthcare providers often feel disadvantaged by the system, noting the lengthy appeals process and the "contingency fees" RACs receive based on the number of improper payments they correct for both

overpayments and underpayments. While lawmakers and health systems call for greater program oversight as CMS takes steps toward incorporating these concerns, there are immediate actions providers can take to protect their integrity and bottom lines.

1. Engage in proper reporting and tracking practices. In order to understand the specifics of why a RAC identified an improper payment, providers first must focus inward. It is important to have a monitoring and tracking system in place that allows one to assess where the institution stands from an audit perspective. For example, software systems are designed so that organizations can continue to enter their information into a portal that automatically identifies any at-risk RAC audit areas and immediately alerts providers, allowing them to proactively correct any errors.

Providers may also find it helpful to have standardized audit definitions and procedures that are understood by designated staff members who are specifically tasked with overseeing all documentation and are particularly familiar with the process' jargon. This team should consider taking note of previously audited records, soon-to-be audited records and areas that are susceptible to audit. In conducting an initial overview assessment, providers are able to view the process more holistically and properly focus and allocate their limited resources to areas where they can have the greatest impact.

2. Review historic data. Once a monitoring system is in place, organizations would be wise to review the areas where they've seen the most claims denied. Breaking down the denials into improper coverage, incorrect coding or medically unnecessary care will help pinpoint the real drivers behind the RAC-identified errors.

As a second step, healthcare professionals can ask, "Was the claim denied on account of actions that are controllable, or is it an issue

that goes beyond the hospital's reach and needs to be appealed?" Drilling down into the details will help providers address whether the claim was denied based on a hospital-implemented process or procedure that can be tweaked, or the result of an individual's actions, and determine if deeper investigation is required. From here, providers can statistically predict the areas where they're likely to have the greatest success when they go to appeal.

It's equally critical that healthcare providers review the success rate of their appeals. The American Hospital Association reports that in the first quarter of 2014, 50 percent of the 1,165 hospitals participating in its RacTrac program – a free web-based survey that collects hospitals' data regarding the impact of the RAC program – reported appealing all RAC denials, with a 66 percent appeals success rate. This information, coupled with a review of internal data, will help providers pinpoint where they will see the greatest return on their investment.

3. Identify the costs. Given the lengthy appeal process, analytical review of the success rate will also help drive the dollars at risk versus the appeal cost. RAC appeals can have a significant organizational impact if the proper systems are not in place. Healthcare providers must be able to accurately weigh the pros and cons of the administrative and financial burden of the process, factoring in the number of hours and effort involved in processing and completing RAC requests, the potential cost of implementing tracking software and the wait time.

A more collaborative approach between CMS and providers is vital to ensuring the RAC program appropriately functions to meet its original goals. In the meantime, organizations would be wise to re-evaluate current practices and address any gaps within their existing structures to proactively protect against costly audits.

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THE LEADERSHIP QUANDARY: COMPETITION FOR TALENT AND CONSTRAINTS ON EXECUTIVE PAY WILL CHALLENGE NONPROFIT HEALTHCARE PROVIDERS

By Steven Shill, CPA, and Mike Conover, The BDO Center for Healthcare Excellence and Innovation



With the Affordable Care Act now in full swing, a challenging new normal has emerged for nonprofit healthcare providers: Not only is there continuous innovation across all fronts of care, there's also a constant pressure to contain costs. Now more than ever before, all healthcare providers need senior management with the skills and expertise necessary to navigate this complex and transforming landscape. As the need for dynamic leaders continues to grow across the industry, nonprofit healthcare providers need to ensure that recruiting, retaining and compensating their senior management keeps pace with the competitive market. Heightened competition coupled with strict constraints on executive pay will require successful organizations to explore new strategies for attracting and rewarding successful top talent.

Developing new recruitment and compensation strategies can be difficult under the best of circumstances. In times of change, the difficulty is compounded. With that in mind, here are four key considerations

around compensation for nonprofit healthcare providers when they are preparing to enter the talent hunt:

- **Higher premiums for talent:** Top leadership positions require experienced and highly skilled executives who can manage complex cost control measures, extensive oversight and reporting and the ability to navigate constant innovation in service delivery and technology. As a result, these leaders are in high demand. Executive compensation levels within for-profit healthcare and other for-profit talent pools are generally higher than nonprofit levels.
- **Limited pay vehicles:** As we've highlighted before on the Nonprofit Standard blog, nonprofit organizations are limited in what they can offer their executives. For example, they are precluded from offering any sort of equity-based compensation or revenue/net-profit sharing incentives. Similarly, there are heavy restrictions around long-term incentives, as well as retirement and deferred compensation.
- **Reasonable offerings:** Tax-exempt organizations must also be mindful of the need to ensure that total compensation is reasonable, avoiding any "excess benefit" that might run afoul of IRS Intermediate Sanctions or similar constraints at the state level.
- **Complex compliance issues:** Alternative compensation arrangements that are available to tax-exempt organizations (e.g., 457f deferral arrangements, executive-owned life insurance arrangements, etc.) can be structured as attractive compensation components to offset those found only in the for-profit sector. However, careful attention must be paid to how such components are structured, documented and administered. Organizations and executive participants that fail to comply with regulations can face onerous tax penalties, loss and repayment of compensation and other severe repercussions.

Perspective in Healthcare

M&A deal value in the healthcare industry reached \$232.2 billion in the second quarter – an almost fivefold increase over the capital deployed during the first quarter of 2014, according to *Modern Healthcare*. Pharmaceutical and medical device companies were the recipients of more than half of these funds, representing the quarter's five largest transactions, which together totaled \$192 billion.

Fortunately for investors, however, it's not all "go big or go home." Other segments, including urgent and emergency care, are presenting compelling investment opportunities for private equity sponsors.

In July, *Forbes* reported that there were more than 10,000 urgent care centers in the U.S., and IBIS World predicts the urgent care sector will grow to more than 12,000 clinics and \$18 billion in revenue by 2017. The growth has already been impressive: In one example, MedExpress Urgent Care, a franchise, has grown from 47 clinics in four states to 130 clinics in 10 states since 2010, a boon for the private equity and venture capital firms that backed it.

Stand-alone emergency care also offers opportunities worth watching. Adeptus Health, the private equity-backed owner and operator of First Choice Emergency Rooms, raised \$93 million in its June IPO, and shares have risen from \$22 to \$27.50 over the first three months. The company's facilities capitalize on the national issue of emergency department overcrowding, a challenge that has been exacerbated as more patients gain access to insurance. In fact, an American College of Emergency Room Physicians study found that almost half of its members had seen a rise in visits since the implementation of the Patient Protection and Affordable Care Act. Adeptus anticipates expanding to 53 facilities by the end of 2014 from the 14 facilities it had just two years ago.

This trend of comparatively small chains, however, could exclude larger private equity firms with minimum purchase requirements from investing in the sector: a potential opportunity for middle market firms. The largest operator of urgent care facilities, Concentra Operation Corp., owned 298 urgent care centers at the end of 2013, about 3 percent of the urgent care market, while the second-largest, Urgent Care MSO LLC, owned 126, according to *The Wall Street Journal*.

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

► DID YOU KNOW...

The **Centers for Medicare & Medicaid Services** projects out-of-pocket healthcare spending will increase by 5 percent or more each year through 2023.

According to consulting firm **Kaufman Hall**, hospital M&A activity dipped slightly in the first six months of this year compared to 2013.

Employer health coverage costs grew by 3 percent, slightly less than 2013's 4 percent growth, reports the **Kaiser Family Foundation** and the **Health Research & Educational Trust**.

According to **CMS** records, hospitals in every state but one will face fines (totaling \$227 million) in the second round of Medicare's readmission penalties.

The number of Americans without health insurance fell by 8 percent to 41 million people in the first quarter of 2014, compared to 2013 numbers, according to the **National Health Interview Survey**.

In the first half of 2014, venture capital firm **Rock Health** says that venture capital funding for companies in the digital health space exceeded \$2.3 billion, more than the \$1.9 billion raised in all of 2013.

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THE LEADERSHIP QUANDARY

Overall, keep in mind that excessive reliance on pay as the primary motivator for recruiting and retaining key executives can produce "coin-operated" leaders, and can inadvertently cause numerous problems. Ideally, an individual's commitment to the organization and its mission is the significant factor in his/her desire to lead. Realistically, however, pay will remain a considerable motivator for nonprofit healthcare executives, and it is therefore critical that organizations and their boards stay abreast of current compensation

trends – both in the healthcare sector and among the for-profit organizations that compete for the same talent.

Article was reprinted from the [Nonprofit Standard blog](#).

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WEARABLE DEVICES: THE CONVERGENCE OF HEALTHCARE AND HARDWARE

By William Bithoney, M.D., FAAP, and Venson Wallin, CPA, The BDO Center for Healthcare Excellence and Innovation and Slade Fester, BDO USA



THE HARDWARE SECTOR IS SEEING SOMETHING OF A REVOLUTION.

While software has enjoyed years of high growth and investor interest, hardware is becoming increasingly attractive thanks to mobile advancements and the growing appeal of wearable technology that are driving growth in data storage surrounding what is now coined The Internet Of Things.

In fact, IDC reports that consumers and businesses will buy nearly 112 million wearable computer devices by 2018, marking a 78.4 percent growth rate from predicted sales for 2014. Healthcare and fitness are key drivers of this growth, and the digital fitness device segment alone grew to \$330 million in 2013, according to NPD Group. But beyond fitness, wearable medical devices look to disrupt healthcare delivery and patient care. This summer, Apple unveiled partnerships with several healthcare providers and a new platform called HealthKit, which seeks to integrate data across providers. According to Apple, with the platform, "your blood pressure app could share its data with a physician app, such as the Mayo Clinic app, so your doctor can provide high-quality guidance and care." Preventice's BodyGuardian Remote

Monitoring System and Avery Dennison's Metria Wearable Technology also seek to deliver patient data from wearable sensors to doctors.

As the line between consumer electronics and medical devices continues to blur, and the demand increases, the opportunity for hardware companies to capitalize on this growing category is clear.

Capitalize on New Market Needs

With innovation becoming increasingly driven by software, and markets in other areas such as personal computers and tablets becoming more mature, hardware companies are at risk of allowing their products to be commoditized. Access to new markets is key to a company's survival in the constantly evolving hardware market. In many cases, the time to market is too critical, and there is no practical way to meaningfully penetrate a new segment without a partner that is already positioned in the market and has adequate capital to execute on a strategy.

When it comes to wearable devices, many healthcare organizations fit the bill as a viable partner that could also help serve as a competitive differentiator. Changes in the healthcare landscape offer tremendous opportunities. Electronic medical records are already fueling increased demand in the

storage market, and the data captured from sensors in wearable devices will also need a home.

Furthermore, as the healthcare model transitions from fee-for-service to value-based care, the interest in population health management is expanding and, along with it, a desire to establish a more integrated relationship between the provider and patient. Wearable devices in healthcare align strongly with this change in strategy. The technology not only benefits the patient in terms of the quality of care received, but also the health system may experience cost savings from fewer unnecessary and costly readmissions, while gaining access to greater amounts of vital patient data.

Wearable devices have strong potential to help manage a variety of conditions. Rather than quarterly lab visits for chronic conditions (diabetes, congestive heart failure, etc.), wearable devices offer more freedom to conduct many of these tests on a regular basis from the comfort of the patient's own home, with little or no disruption to daily routines. For example, physicians use weight gain as a key metric in managing congestive heart failure. Digital scales can wirelessly communicate all patient data to a healthcare system that can alert physicians to a patient's worsening condition. When doctors are aware of these developments, they're able to adjust the patient's medicine prospectively prior to the patient deteriorating and requiring hospitalization.

This technology not only proves much more convenient to the patient, but it also opens the door for a mutually beneficial and innovative relationship between hardware and healthcare as companies look to develop hassle-free, real-time health monitoring devices.

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PROTECTING AGAINST EMR PITFALLS

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

IT'S HARD TO BELIEVE, BUT ELECTRONIC MEDICAL RECORDS (EMRS) ARE NOW MORE THAN 40 YEARS OLD.

During that time, they have evolved significantly, with each advancement designed to increase efficiencies in the healthcare system. However, with these changes come challenges, from steep learning curves among users to complexities unearthed while in use.

Today, EMRs could be considered both a blessing and a curse, if not used properly. Many of the time-saving features associated with EMR systems carry risks. Functions such as copy and paste, templates and autocomplete make supporting higher levels of service easier, but they also increase and facilitate scrutiny by payers and governmental entities.

Add to that the fact that accuracy is crucial. A provider's signature on an EMR note validates that he or she has performed the services documented. But in today's healthcare environment, where demand for services is increasing as more people gain access to health insurance and the population ages, reviewing every word in each note is no longer a luxury providers can afford.

Today, it's more important than ever that healthcare leaders actively monitor and mitigate the risks associated with three common EMR pitfalls:

► PITFALL ONE: AUTOCORRECT

Autocorrect is a relatively new feature that can contribute significantly to the complexity of EMRs. While it can lead to time savings when it works correctly, it can cause significant reporting issues when it doesn't. To mitigate the risk of reporting inaccurate information, physicians using a program that has autocorrect should add all of the medical terms used within their practice(s) to the system. If "IUD" is meant to document "intrauterine device," providers should verify

that term is what populates and not, for example, "intrauterine death." Confirming that the source information from which autocorrect pulls is as complete as possible will allow the program to operate smoothly and create the intended efficiencies.

► PITFALL TWO: PRINTING THE RECORD

Once an EMR is in place, another step that is often overlooked is the printing of records. As the healthcare industry transitions from hard copy to digital, it's important that providers do not lose sight of what the records should and will look like if printed. Why? Many outside entities will continue to request hard copy records for auditing purposes, and there are often significant visual formatting differences between paper and electronic documents, which can include the omission of details or the inclusion of irrelevant data. It's crucial to understand these differences to avoid the lengthy and costly process associated with a claim denial.

► PITFALL THREE: BASING ASSESSMENTS ON A CODE SET

Basing assessments on a code set is another feature, intended to save time, which can cause issues if not used correctly. Certain EMRs, for example, require providers to select an ICD-9 code for their assessments, which match from the record to the claim. However, if the provider selects the wrong code, issues arise from a coding and auditing perspective. Furthermore, the fast-approaching implementation of ICD-10 has additional implications for EMR coding, particularly given that some payers – those that aren't HIPAA-covered entities (e.g., workers' compensation and auto insurance carriers) – are not required to update to ICD-10.

Combined, these EMR pitfalls can create additional administrative work for providers and, more importantly, put their claims at risk. For example, if a pregnant patient is seen for a condition unrelated to pregnancy, coding guidelines direct providers to add the code V22.2, "pregnant state, incidental." However, consider this scenario: a chiropractor saw a patient and treated the non-pregnancy-related issue, but then completed his documentation and selected a code to represent that the patient was pregnant. The first code to appear when the provider searched "pregnant" was "abdominal pregnancy" because the codes were listed in alphabetical order by code descriptor. He therefore selected the code 633.01, "abdominal pregnancy with intrauterine pregnancy," and it populated his note and claim form with this information. The full descriptor, which the EMR didn't have the character space to accommodate, went on to state that this was an ectopic pregnancy. Now both the medical record and the claim form were incorrect, which meant the provider had to do an addendum and re-document the condition appropriately. This is a prime example of when a time-saving feature created an error that put the claim and documentation at risk, while also creating more work and expending more time and effort than should have been required.

EMRs are great tools, but they are just that – tools. It is up to the individual to correctly use all of the resources at his or her disposal. Being aware of a system's shortcomings, as well as the areas in which they function best, will ultimately help providers reap the greatest benefit from this technology.

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UNCERTAINTY CONTINUES IN THE HEALTH INSURANCE MARKETPLACE

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

TODAY'S EVOLVING HEALTHCARE LANDSCAPE HAS FORCED MANY HOSPITALS TO RETHINK THEIR CHARITY CARE POLICIES AND SCALE BACK EFFORTS TO HELP ELIGIBLE INDIVIDUALS WHO HAVE NOT YET SIGNED UP FOR MEDICAID COVERAGE.



According to a June 5, 2014 update from the Congressional Budget Office (CBO), the CBO and the Joint Commission on Taxation estimate that 30 million non-elderly residents will be uninsured in 2016. The majority of these people will not be paying a tax penalty due to the growing number of exemptions from the Patient Protection and Affordable Care Act (PPACA) requirements.¹ Further compounding the issue, as of August 2014, 24 states had decided not to implement the Medicaid expansion in 2014.²

This creates a coverage gap for individuals with an annual income below 138 percent of the federal poverty level because the PPACA envisioned that this population would receive Medicaid, many of them will also not qualify for tax credits. This coverage gap creates additional uncertainty in an already uncertain health insurance marketplace, with millions of adults likely to remain outside the reach of the PPACA and have limited options for healthcare coverage.

What does this uncertainty mean for healthcare providers?

► UNCLEAR GUIDELINES LEAVE LINGERING QUESTIONS

In addition to anticipated coverage gaps, the final rules of the PPACA are not yet clear. Specifically, the case of *Halbig v. Burwell* challenges the legality of an IRS rule authorizing tax credits for the purchase of health insurance in federal exchanges. *Halbig* claims that the PPACA text only allows tax credits and subsidies for the purchase of insurance on exchanges that were established by the State under Section 1311.³ The underlying question is, "Are subsidies illegal in federally run exchanges?"

In July of this year, a three-judge panel for the U.S. Court of Appeals for the D.C. Circuit ruled in favor of the plaintiff, *Halbig*. Then, in August, the federal government filed for a rehearing en banc in this case.

The pending outcome of the rehearing creates additional uncertainty for healthcare providers. If the decision stands, five million Americans who received subsidies in the federally-run exchanges could be affected.

Until then, the question remains and individuals who received subsidies, and selected and enrolled in a health insurance plan in the marketplace will see an increase in premiums or be cut off.

Moving forward healthcare providers will need to monitor the pre-registration and financial clearance processes more closely to ensure these systems are securely in place and working. Assisting patients through the financial process, communicating expectations and responsibilities, and collecting at the time of service will all be critical to cash flow and providers' credibility.

► 90-DAY GRACE PERIOD CREATES COVERAGE CONFUSION

Healthcare providers are also facing challenges as they work to verify if coverage is applicable and in place for those covered through the marketplace. Specifically, many providers cite complications on account of the 90-day grace period where the carrier states valid coverage when the premium has not yet been paid.

According to the Department of Health and Human Services, eight million Americans were enrolled in a marketplace plan as of April 19, 2014. However, the exact number of those still enrolled remains unknown.

To avoid pitfalls associated with the 90-day grace period, organizations should check their processes, ensure timely follow up, and monitor and measure denials by health insurance plans. If the denial rate is greater than 3 percent of the overall claims submitted for one month, providers should consider performing detailed analysis and research to drill down to the root cause.

It is also important to note that American National Standards Institute and Electronic Data Interface codes have been created for plans purchased through the health insurance marketplace to track if a patient paid his or her premium (if coverage was purchased on

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UNCERTAINTY CONTINUES

the exchange). Organizations should check if their systems and workflow processes accommodate these critical elements.

▶ NARROWING NETWORKS COMPLICATE THE PAYER MIX

It is also critical that providers closely monitor the continued trend among employers to shift more and more healthcare costs to employees. According to the research firm S&P Capital IQ, by 2020, 90 percent of American workers who currently receive health insurance through employers will be shifted to the exchanges.⁴ Providers can no longer assume that employees have good payments/coverage based on their monitoring of the employer group health insurance plan. Going forward, many employers will have deductibles as high as \$5,000 or more before the insurance payments take effect.

Today's evolving healthcare landscape presents an uncertain future for healthcare providers. However, there are steps they can take today to prepare for the future. Providers should fully understand the importance of financial clearance and communicating expectations and financial responsibility to patients, which will not only increase cash flow but also assist in monitoring and tracking payer denials. Organizations that plan now and allocate resources to safeguard against pitfalls will come out of today's stormy waters to see the clear skies ahead.

1 <http://www.cbo.gov/publication/45397>

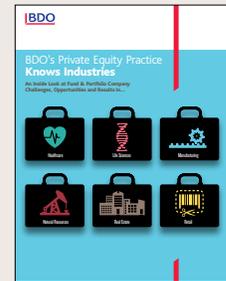
2 <http://www.washingtonpost.com/blogs/wonkblog/wp/2014/08/12/wonkbook-the-ever-expanding-medicare-expansion/>

3 <http://www.washingtonpost.com/news/volokh-conspiracy/wp/2014/07/08/halbig-v-burwell-the-next-big-obamacare-case/>

4 http://www.nytimes.com/2014/05/01/upshot/employer-sponsored-health-insurance-may-be-on-the-way-out.html?_r=0&abt=0002&abg=0

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BDO'S PRIVATE EQUITY PRACTICE KNOWS INDUSTRIES eBook



In times of great change, it's more important than ever that private equity fund managers engage partners who understand their industry and the industries in which they invest. In the healthcare industry, fund managers need advisors who recognize the increasingly complex environment they're working within and the challenges they face when sourcing and closing deals, growing their portfolio companies and, ultimately, exiting their investments. BDO's integrated, multidisciplinary teams support private equity funds and their portfolio companies across the globe and in more than 15 industries with a full spectrum of professional services.

This eBook offers an inside look at how BDO's Private Equity practice has worked with funds and portfolio companies across a number of industries, including: healthcare, life sciences, manufacturing, natural resources, real estate and retail.

Download the eBook here: www.bdo.com/download/3104.

MARK YOUR CALENDAR...

NOVEMBER 2014

November 6-7
AICPA Health Care Industry Conference
 Bellagio
 Las Vegas

November 14-18
ACPE's 2014 Fall Institute
 Fairmont Scottsdale Princess
 Scottsdale, Ariz.

November 17
2014 Medicare Advantage Business Strategy Summit
 Hilton Alexandria Mark Center
 Alexandria, Va.

DECEMBER 2014

December 3-4
Forbes Healthcare Summit 2014
 Lincoln Center
 New York City

December 10-11
11th Annual AHCC Presents The Stakeholder Health Forum
 Sheraton Pasadena
 Pasadena, Calif.

JANUARY 2015

January 28-29
The 6th Annual Leadership Summit on Readmissions
 Hilton Atlanta Airport
 Atlanta

January 28-29
ACO Population Health Management Summit
 Hilton Atlanta Airport
 Atlanta

January 29-30
Post-Acute Care Annual Conference
 Hilton Waterfront Beach Resort
 Huntington Beach, Calif.

* Indicates that BDO representatives will be present at conference.



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