Healthcare Trends & Topics
WEBINAR SERIES

REVENUE CYCLE OPTIMIZATION AND HEALTHCARE REGULATORY COMPLIANCE

April 11, 2023

BDO

CPE and Support

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To receive CPE credit for this webcast:

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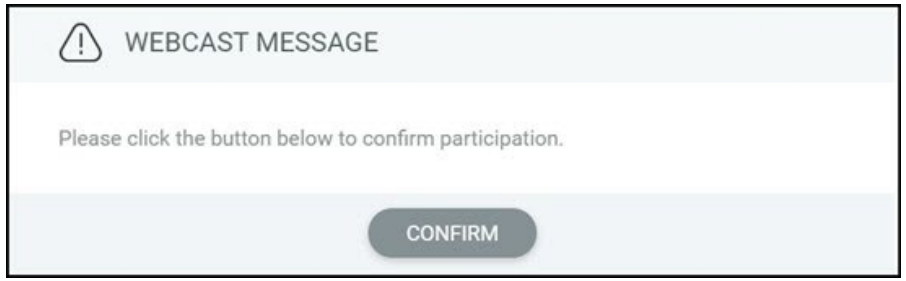
- For each CPE credit hour, you must:
  - Respond to at least 3 checkpoint pop-ups/polls
  - Be in attendance for at least 50 minutes

Sample Checkpoint Pop-up



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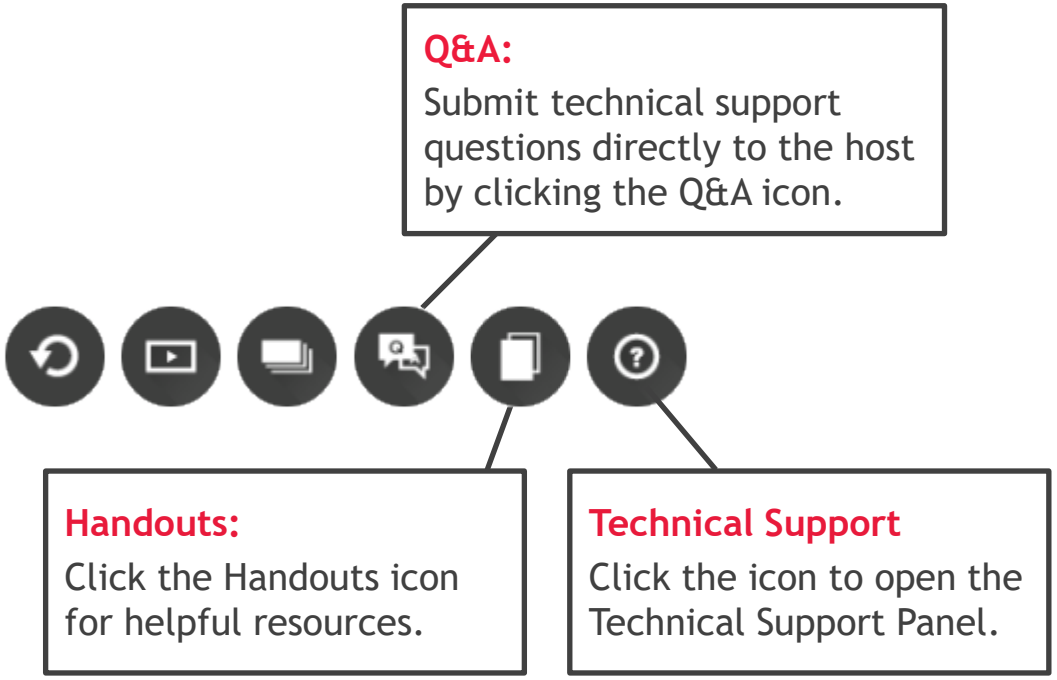

Welcome

BRAD BOYD

Healthcare Consulting National Leader

The BDO Center for Healthcare Excellence & Innovation

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Learning Objectives

- Describe timely regulatory and compliance updates affecting the healthcare industry.
- Demonstrate familiarity with the latest regulatory changes and effective compliance strategies for healthcare organizations.
- Discuss the latest issues-based topics and trends in healthcare and related industries.

With You Today

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Spotlight: Preparing for Healthcare's Regulatory Environment Shift

Venson Wallin

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End of the Public Health Emergency

The Biden Administration Will Let the Federal Public Health Emergency (PHE) for Covid-19 End on May 11, 2023

- The end of the Covid-19 Public Health Emergency will end or sunset some regulatory changes that greatly benefited providers.
- This change will begin on May 11, and will result in a monumental shift in both compliance and financial burden. Other changes expected to come online soon will also increase compliance burdens.
- For providers who are reliant on Medicare and Medicaid reimbursements, it is especially important to pay close attention to these new regulations and prepare accordingly.

End of the Public Health Emergency

FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES

What Changes

- Some waivers, flexibilities and regulations that affect care delivery and payments will end.
  - Some Medicaid and Medicare flexibilities will end on May 11th, and others will remain for another six months. States can decide to keep some of these changes beyond the PHE.
- The big one: 20% reimbursement for hospital COVID-19 treatment costs go away and millions of people will lose their Medicaid coverage – This means a large increase in bad debt for providers.
- Other changes
  - Private insurance will no longer be required to cover COVID-19 tests without cost sharing.
  - Public Readiness and Emergency Preparedness (PREP) Act liability protections will begin to sunset in 2024 for some public and private organizations.
  - The FDA is evaluating which industry guidance documents affecting clinical practice and supply chains will be temporarily extended or ended.
  - The ability for providers to dispense controlled substances via telemedicine (without an in-person interaction) is scheduled to end, but new rules will be proposed to extend flexibility in this space.

What Doesn't Change

- The FDA's emergency use authorizations (EUAs) for COVID-19 tests, treatments and vaccines will not be impacted, nor will access to these products be affected.
- State Medicaid Programs will have the option to continue covering all COVID-19 vaccinations through September 30th, 2024.
- State Medicaid Programs will have the option to continue to cover COVID-19 treatments through cost sharing up to September 30th, 2024.
- Many Medicare and Medicaid telehealth flexibilities will not be affected.

Discussion Question #1

How much will the end of the Public Health Emergency affect your organization financially?

A	Extremely
B	Moderately
C	Somewhat
D	Not at all
E	N/A

Overview of Other Specific Regulations/Changes

- There are other regulations both related and unrelated to the end of the Public Health Emergency that providers will need to be attuned to.
- Many of these will increase compliance burdens and decrease Medicare/Medicaid reimbursements.

Medicare Payment Advisory Commission (MedPAC)

Plan for Congress to Overhaul Medicare DSH Pay-phase Out of Medicare DSH and Uncompensated Care Payments to be Replaced by a Safety-Net Index

The new Medicare Safety-Net Index replaces the disproportionate share hospital (DHS) payment system, which also factored in uncompensated Medicare payments.

New metrics for Medicare Safety-Net Index payment system

- Compensations for claims filed for Part D low-income subsidy beneficiaries will be based on the hospital's share of inpatient and outpatient claims.
- Uncompensated care costs will now be counted as a share of revenue.
- Medicare will reduce its share of coverage of a hospital's inpatient days by half.
- These changes could possibly negatively impact the reimbursement for Safety-Net hospitals that treat large low-income, non-Medicare populations.

Medicare Payment Advisory Commission (MedPAC)

Plan for Congress to Overhaul Medicare DSH Pay-phase Out of Medicare DSH and Uncompensated Care Payments to be Replaced by a Safety-Net Index

Goal set by MedPAC is to improve Medicare profitability for hospitals with low-income, high Medicare patient populations.

To achieve an improvement in margins from 3.1% to 4.4% (an improvement mentioned by MedPAC), an additional $2 billion would be needed to supplement the change to the Safety-Net Index. Whether Congress would authorize such funding is yet to be seen.

The Safety-Net Index presents new challenges:

- Hospitals which serve large low-income, non-Medicare patient populations may see reduced Medicare reimbursements. Safety net hospitals may also see reimbursements reduced under the new index.
- A stop gap entailing a transition period between existing DSH and uncompensated care funding, and the new system will hopefully be considered.
- A stop-loss policy should also be considered to prevent hospitals from experiencing a Medicare payment change of over 5% in any given year.

CMS TRANSMITTAL 18

New Medicare Reporting Requirements

- Managing Medicare bad debts and UCC has become increasingly more complicated for cost reports beginning on or after October 1, 2022.
- The first reports that will encounter these complications are those that end September 30, 2023. CMS Transmittal 18 will require hospitals to take on increased reporting requirements when filing these Medicare cost reports.
- These reporting requirements include the submission of more detailed demographic and payment data. To this end, CMS has provided new templates, additional worksheets and new instructions.
- These wide-ranging changes will affect how hospitals report charity discounts, bad debt and Medicaid eligible days.

These new requirements and instructions will increase hospital compliance burdens. Failure will result in

- Cost report rejections
- Increased risk of an audit
- Possibly lower Medicare/Medicaid reimbursements

Providers should exercise extra caution when engaging with these new requirements for the first time.

340B Acquired Drugs Changing to ASP Plus 6 Percent

- When drug companies raise prices for Medicare Part B drugs faster than the rate of inflation, they are required to pay Medicare a rebate.
- Over the past several years, payments were cut, and Medicare is now required to reinstate the reimbursement.
- Medicare is required to pay the average sales price (ASP) for many Part B drugs and biologics, plus an additional 6%, according to this change.
- Back in 2018, Medicare paid 340B hospitals for Part B drugs and biologics at ASP minus 22.5%. This change to ASP plus 6% is a nearly 30% increase in reimbursement for Part B drugs and biologics.
- This win for 340B hospitals comes at the cost of the Outpatient Prospective Payment System (OPPS) rate increase in FY 2023. Due to the budget neutral nature of 340B payments, the increase in reimbursement for 340B drugs means that those payments would need to be taken out of the overall OPPS rate increase. This will impact rural hospitals and smaller urban hospitals in a significant manner.

- The increased payment rate for OPPS is 3.8% for calendar year 2023 compared to 2022, without the 340B increase.
- Due to the change in 340B reimbursement, CMS is instituting a budget neutral adjustment of 3.09% to offset the increase in payments.
- CMS estimates this will result in an increase of only .9%.
- This increase has not been met optimistically by hospitals who do not believe it will ease the ongoing increase cost of care burden.

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Discussion Question #2

Which new regulation do you need the most assistance with?

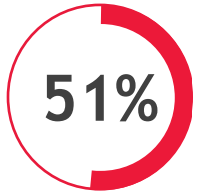
A	MedPAC
B	CMS Transmittal 18
C	ASP Plus 6 percent
D	2023 Outpatient rules
E	All of the above
F	N/A

ESG Is Coming

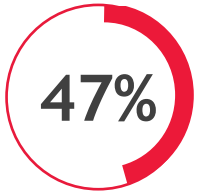
PROPOSED CHANGES

- ESG-2023 Medicare IPPS rules and the attached CMS Equity Framework
  - 2024 inpatient rules will be released in mid-April 2023, which will include the health equity key metrics.
  - These metrics, based on the CMS Framework for Health Equity, will be more objective than the 2023 Framework's more subjective metrics.

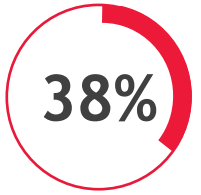
HEALTHCARE CFOS' TOP THREE GOALS FOR ESG PROGRAMS



Create value across the organization



Reputational and brand benefits of external reporting



Improve governance practices

Many healthcare CFOs confirm that ESG and health equity efforts are essential to improve patient care and organizational value

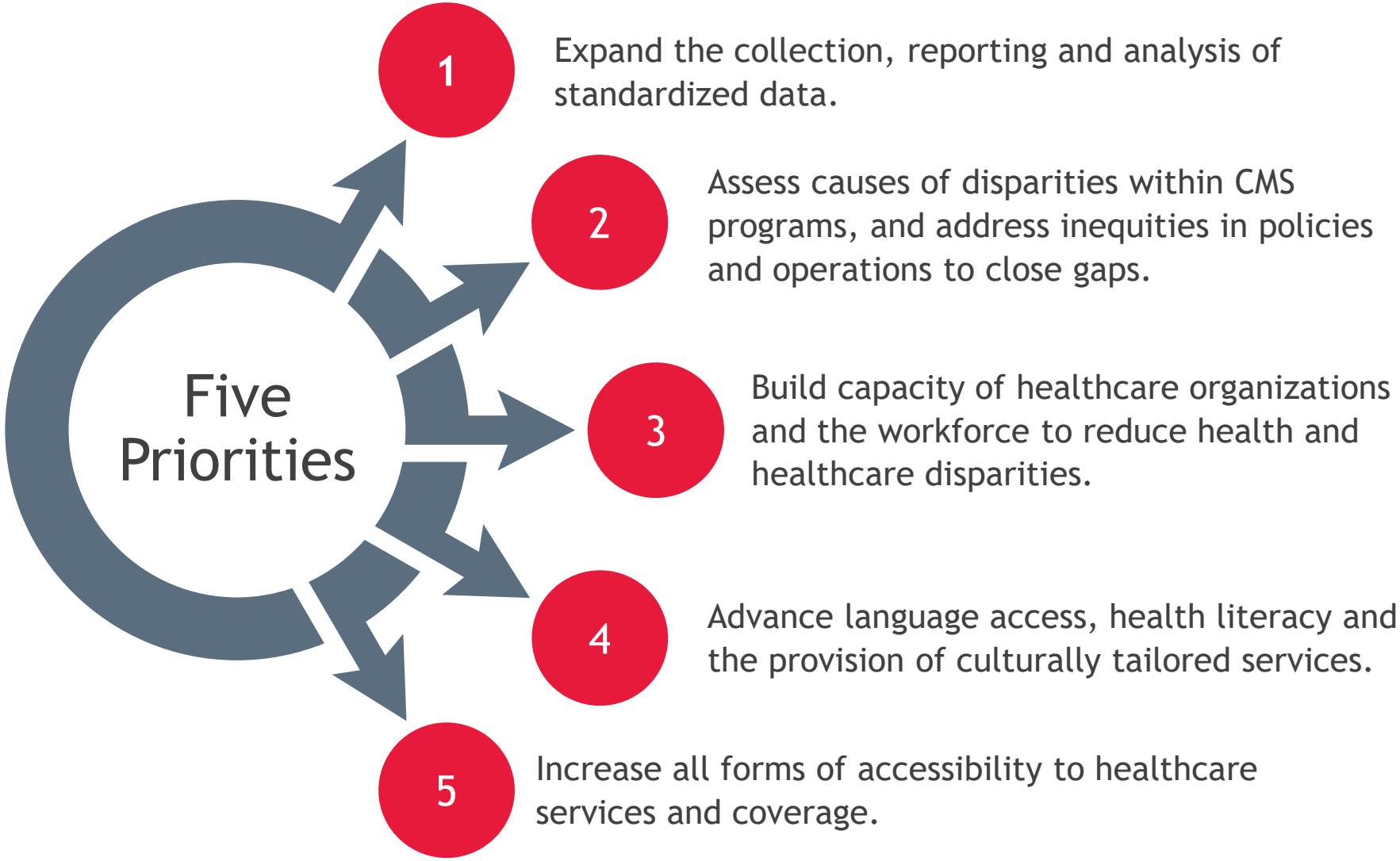
59% think an ESG program will have a positive impact on their long-term financial performance

35% are investing to improve health equity

32% will pursue an ESG strategy in the next year

The CMS Framework for Health Equity

2022-2032



Discussion Question #3

How prepared are you to implement the upcoming CMS Framework for Health Equity?

A	Extremely
B	Moderately
C	Somewhat
D	Not at all
E	N/A

How To Prepare

THE CMS FRAMEWORK FOR HEALTH EQUITY 2022-2032

- Identify health inequities.
- Signaling out health inequalities in your patient population and providing tangible metrics on progress will be critical to becoming compliant with future regulations related to equity.

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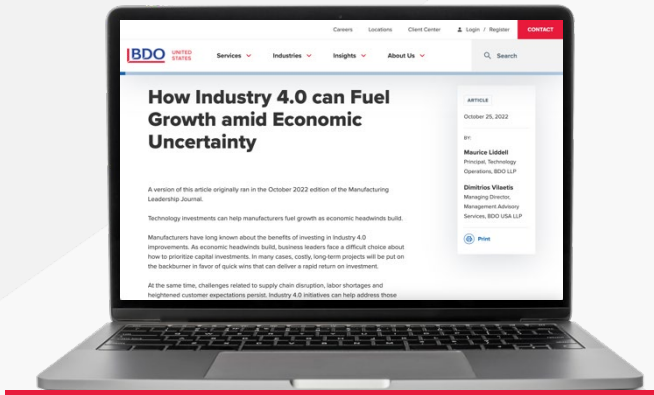
OIG Medicare Bad Debt Report

- OIG randomly selected 67 cost reports and 148 samples of bad debts that totaled $450,687.
- Of these samples, 22 bad debts resulted in CMS incorrectly reimbursing providers $29,787.
- CMS reimbursed these amounts because the Medicare administrative contractors (MACs) did not concentrate on reviewing bad debts when performing audits of cost reports.
- Currently, hospitals are reimbursed 65% of their bad debt.
- Bad debt occurs when Medicare recipients cannot pay their share of the cost of healthcare.
- OIG believes that additional reporting requirements from CMS will reduce the chances hospitals receive unallowable Medicare reimbursements.

This may lower the amount of bad debt hospitals can be reimbursed for and puts an additional burden on auditors. Closer scrutiny of Medicare bad debts could increase hospital financial stress.



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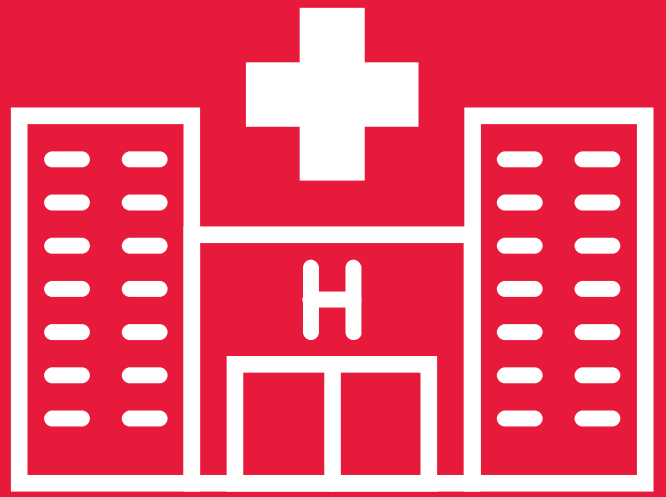
In Summary

- With the end of the Public Health Emergency and the introduction of new Medicare/Medicaid regulations, providers face a perfect storm.
- Greater compliance burdens and new regulations will lead to fewer reimbursements, and an increase in bad debt will coincide with lengthening payment cycles. Many hospitals don't have the cash reserves to take a shock like this.
- How hospitals may respond:
  - Many small or rural hospitals will close or affiliate with larger health systems.
  - Hospitals may shutter some departments or shift their offerings to serve more profitable patient populations.
- The most important thing for providers to do now is to understand how these regulations (proposed and finalized) could impact their financial standing and take action to prepare, now.



Spotlight: Improving Financial Standing with Revenue Cycle Optimization

Rachel Verville

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IMPACT

End of Medicaid Continuous Enrollment Provisions

The continuous enrollment provisions allowed under the FFCRA ended on March 31st.

- Key dates:
  - **2/1/2023** States allowed to issue renewals to Medicaid enrollees
  - **3/31/2023** Continuous enrollment condition ended
  - **4/1/2023** States can terminate Medicaid enrollment following redetermination
- States **must** initiate renewals for all enrollees within 12 months of the "unwinding period“ that began on 4/1/2023 and must complete all redeterminations within 14 months
- Given the concentrated nature of conducting all renewals during the same 14-month period, the number of enrollees who will be dropped because they do not adequately respond to renewal requests and become uninsured is likely to be quite large
- Medicaid pending inventory will likely rise as patients who are dropped attempt to re-enroll

RECOMMENDATIONS

Medicaid Redetermination Impacts

What can providers do in response to the end of the continuous enrollment provisions?

- Enhance eligibility and coverage discovery routines and resources, including timing, to rapidly and continuously identify changes in patient coverage
- Work with referral sources, third-party services/tools, and community organizations to help patients with re-enrollment
- Enhance protocols associated with financial advocacy/counseling, including implementing workflows based on a decision tree to evaluate coverage options for uninsured patients
  1. Medicaid eligibility screening
  2. Employer-sponsored insurance options (losing Medicaid coverage is considered a qualifying life event)
  3. ACA plan options
  4. Grants/funds
  5. Financial assistance/charity care
  6. Payment plans

RECOMMENDATIONS

Medicaid Redetermination, Continued

What can providers do in response to the end of the continuous enrollment provisions?

- Increase clinical department awareness so that they can help assess potential impacts, advocate for patients, and direct/educate patients who are at risk
- Government Advocacy
  - Join with professional associations, MCOs, hospitals, hospital associations, and other advocacy groups to establish communication pathways with states to:
    1. Obtain detailed information on state plans to handle redetermination processes
    2. Request and receive ongoing updates on progress and issues
    3. Communicate rapidly as any/all issues start to surface
- Consider evaluating reserves using periods prior to the PHE and continuous enrollment condition to project impact of growth in uninsured on bad debt/uncompensated care

Common Financial Challenges

REVENUE CYCLE OPERATIONS

Inefficiencies in Revenue Cycle Operations Result in Common Challenges Like

Decreasing volume, net revenue and an eroding cash position

Increasing denials and accounts receivable balances

Inefficient clinical documentation, charge capture and coding

Failing to meet quality and financial performance benchmarks

Discussion Question #4

What is your largest revenue-related financial concern?

A	Declining patient volume (Inpatient)
B	Declining patient volume (Outpatient/ambulatory)
C	Declining patient volume (Surgery)
D	Declining all patient volume (Inpatient, Outpatient/ Ambulatory, Surgery)
E	Increasing aged AR balances
F	Declining reimbursement/erosion in net collections
G	Quality & risk-based contract performance
H	Denials
I	N/A

Improving Financial Health

OPTIMIZING REVENUE CYCLE OPERATIONS

Optimize Roles, Processes, and Technology

1 Assessment

Identify key priorities based on what is most likely to produce financial improvement in the shortest amount of time.

2 Enablement

Initiate data collection, analysis and benchmarking to understand where things stand in your organization compared to others in your industry.

3 Discovery

Examine pre-visit, front-end, mid-cycle clinical/operational, mid-cycle financial/ operational, and back-end workflows, as well as metrics, technology and staffing enablement.

4 Development

Build a revenue management optimization plan that is focused on volume growth, net revenue improvement, and cash acceleration.

5 Optimization

Design and implement improved workflows, staffing models, and reconfigured technology systems. Provide training to employees, including physicians and other members of the care team.

Actionable Steps You Can Take

OPTIMIZING ROLES

- **Create a Clinical Document Integrity (CDI) team.** Support physicians and other clinicians with complete and accurate clinical documentation, including the specificity of current conditions to allow for accurate and timely coding. Clinical Documentation Specialists should have both clinical, typically nursing, and medical coding backgrounds.
- **Formalize your relationships with payers.** Ensure your payer contracts include clearly defined escalation processes to address denial and payment issues in a consistent, timely and standard manner with minimal ambiguity.

Actionable Steps You Can Take

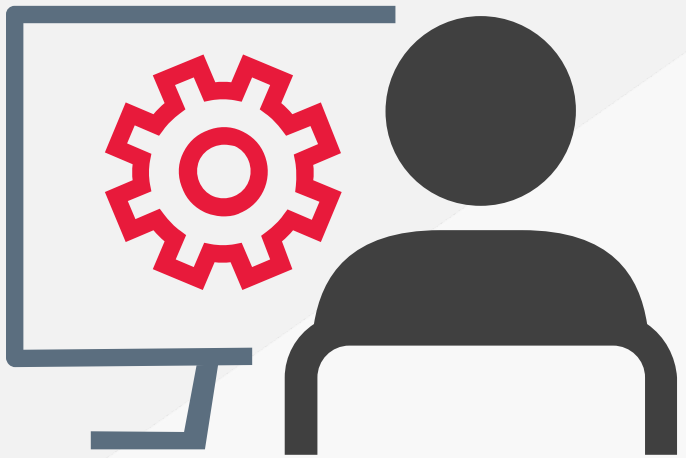
OPTIMIZING PROCESSES

- **Design and implement a Denial Management Program.** Focus on creating a program with efficient workflows so you can address denial-related errors as quickly as possible. Your process needs to include data gathering, root cause analysis, and clinical and financial expertise to drive process improvement recommendations.
- **Create a process for handling post-payment audits.** Have a standardized process to increase speed, efficiency and accuracy for handling the complexities of post-payment audits.

Actionable Steps You Can Take

OPTIMIZING TECHNOLOGY

- **Reduce interruptions with automation.** Look for opportunities to automate high touch areas and reduce manual touchpoints in areas like front-end access, claims management, claim follow-up, contract management, and cash application and management.
- **Use AI and RPA to streamline your processes.** Stay abreast of/**explore advancements** in integrated technologies like robotic process automation (RPA) and artificial intelligence (AI) to **reduce your staff's day-to-day work activities.**
- **Optimize your electronic health record (EHR) and supporting technology.** Get the most value out of your EHR system and ensure it efficiently supports your IT, clinical, and revenue cycle workflows.



A Client Case Study

Achieving a $41 Million Increase in Monthly Charges Through Revenue Cycle Optimization

THE CHALLENGE

An academic medical center with seven hospitals and 1,700 physicians was facing several costly challenges including a lack of KPI management, an unoptimized legacy EHR system with numerous third-party systems, inefficient processes, and an absence of standardization. The organization also had initial and terminal claims denials accounting issues for more than $10 million worth of revenue and approximately $3.3 million of bad debt annually.

A Client Case Study

OUR SOLUTION

BDO performed a comprehensive assessment of the medical center's revenue cycle operations to understand current state and rethink its revenue cycle management processes. Efforts included validating performance metrics and identifying opportunities for improving the efficiency and effectiveness of operations. From there, we worked to develop and implement a performance improvement roadmap. As part of this strategy, we took the following steps

- We redesigned the organizational structure to more effectively allocate staff to workstreams and reviewed and revised job descriptions to align roles and responsibilities with effective use of the organization's EHR system.
- Our team consolidated payers/plans to improve registration and real-time eligibility (RTE).
- We improved dashboard and KPI reporting to provide supervisors, managers and executive leadership with visibility into revenue cycle performance.

THE RESULT

- The medical center experienced a $41 million increase in monthly charges, a reduction in claims denials and improved its Cost-to-Collect from the bottom quartile to above the industry median (Vizient/FPSC).
- Overall accounts receivable decreased by 17%, despite a 6% increase in volume.
- Days in accounts receivable were reduced by 26%.

How BDO Can Help

BDO's Revenue Cycle Optimization solution helps you gain an in-depth view of your revenue cycle, from registration and scheduling, through clinical documentation and coding, to back-end billing and accounts receivable management. Through this solution, we help our clients

- Protect insurance revenue
- Accelerate insurance cash collections
- Improve accuracy of documentation and coding to support appropriate reimbursement and billing compliance

Spotlight: Financial Improvement for PE-backed Physician Groups

Jim Clayton

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Discussion Question #5

Which of the following best describes you?

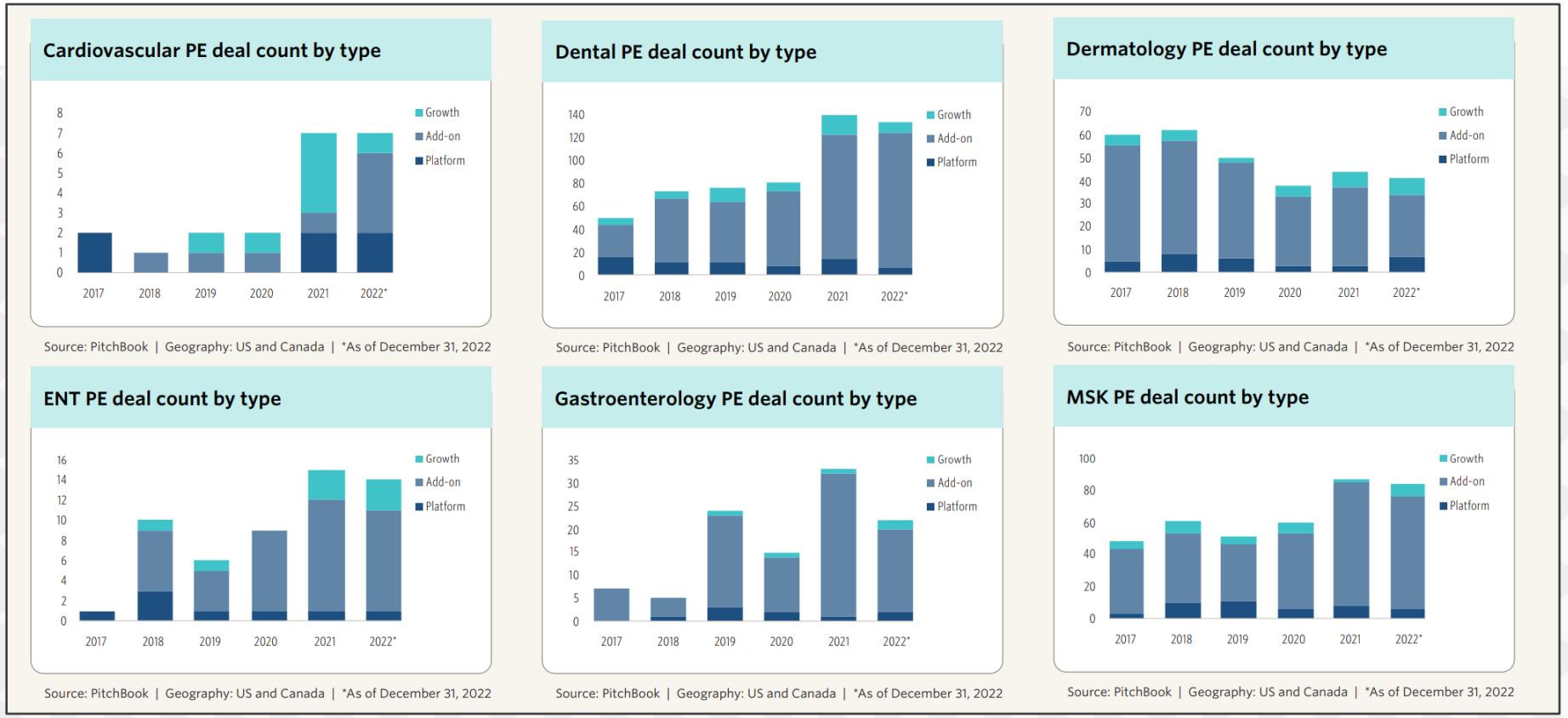
A	PE firm
B	PE-backed healthcare provider
C	Healthcare provider interested in taking on capital partners
D	Healthcare provider NOT interested in taking on capital partners
E	N/A

PE Activity

- Many physician practice management (PPM) groups are taking on capital partners to grow and survive amid heightened competition, rising costs and an increase in risk-based contracting.
- Private equity investment can enable providers to secure more solid footing, so they can focus on patient care.
- While the opportunities for private equity firms are numerous and often advantageous, there is always some risk that can threaten to outweigh any gains from the investment.

PPM Landscape

According to Pitchbook, the landscape for physician practice management companies (PPMs) looks robust, as these companies are less exposed to staffing shortages.



Source: Pitchbook

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PE Investment

THREE PHASES

PE Investment Typically Has Three Phases

Phase 1

INITIAL PRIVATE EQUITY TRANSACTION

- To receive a PE investment, physician practices must set up a separate legal entity that houses all non-clinical operations, a management services organization (MSO).
- The physician practice offers a certain percentage of their equity to the PE firm in exchange for upfront capital.

Phase 2

ACCELERATED GROWTH PERIOD

- The physician practice undergoes a period of accelerated growth through acquisitions, identifying inefficiencies, implementing infrastructure to support value-based care, and adding new services – seeking to enhance the value of the equity.
- Private equity firms commonly invest for 5-7 years.

Phase 3

EQUITY RE-SALE

- The last stage is equity re-sale. PE firms create returns for their shareholders through selling higher-valued equity organizations like the following
  - Another PE firm
  - Strategic buyer (hospital, health system, payer, or other entity outside of healthcare)
  - The general public (IPO)

Improving Finance And Operations

WHEN PREPARING FOR AN EXIT

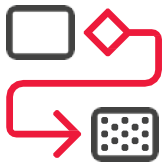
Common Challenges Private Equity Investors in Healthcare Face Include

Overvaluation and inaccurate capital market analysis

Absence of benchmarking data against competitors

Integration of EHR systems across multiple investments

Lack of standardized financial organization



Operational and staffing inefficiencies

Improving Finance And Operations

ACHIEVE KEY OUTCOMES

Creating foundational change across finance and operations enables you to:

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A Client Case Study

Integrating Urgent Care Providers' Record Systems and Transforming Finances After Acquisition

THE CHALLENGE

A private equity firm that owned an urgent care provider group with more than 100 locations in three states purchased another group of urgent care clinics operating under two different names with nearly 90 locations in five states. Both urgent care groups had multiple challenges that needed to be addressed during integration. This included the use of two different electronic health record (EHR) systems, as well as different claim platforms, an absence of standardized financial reporting and auditing practices, and operational inefficiencies in staffing, documentation and finance.

A Client Case Study

INTEGRATING URGENT CARE PROVIDERS' RECORD SYSTEMS AND TRANSFORMING FINANCES AFTER ACQUISITION

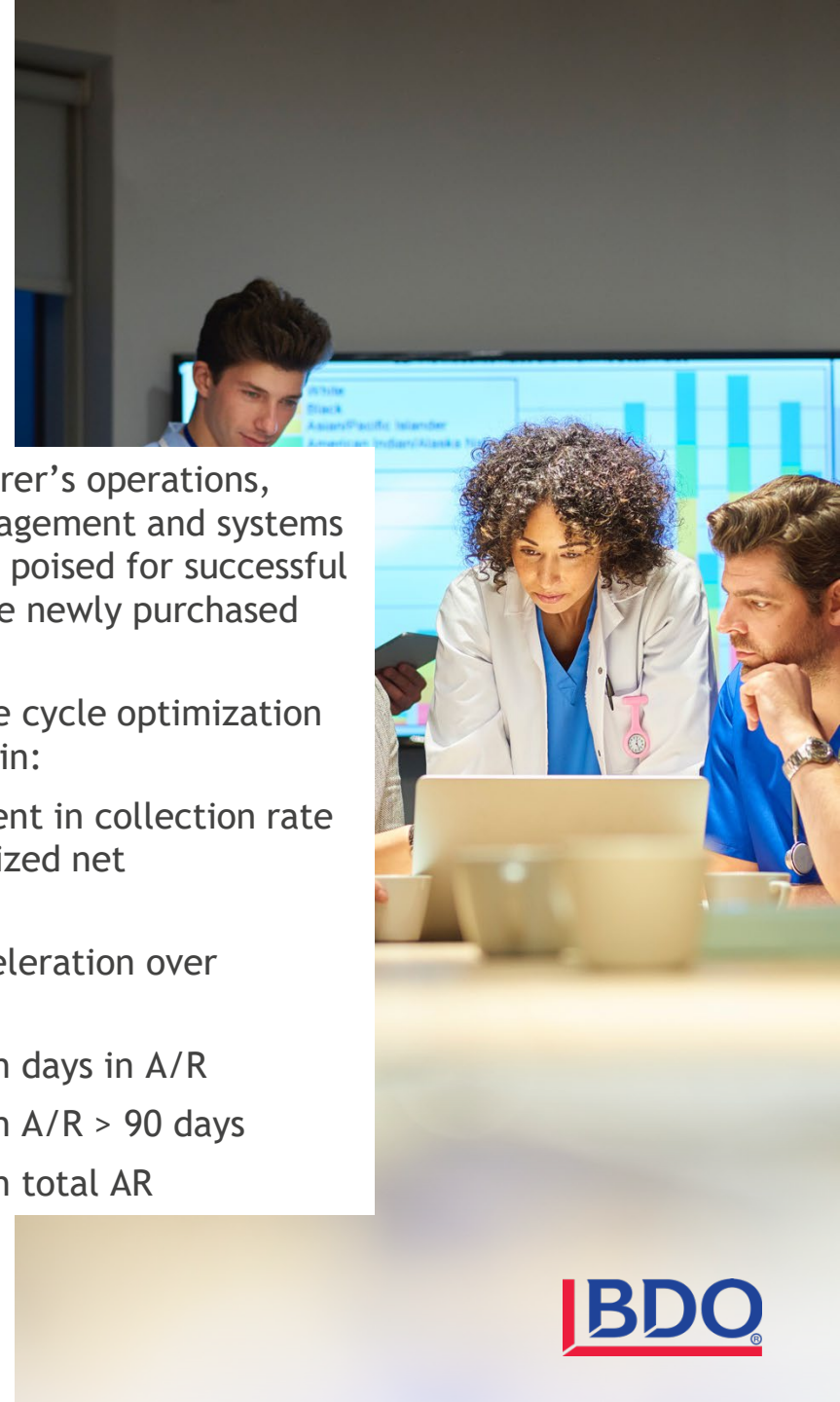
OUR SOLUTION

To enable the best client outcomes, we assembled an experienced, multi-disciplinary team from several BDO business areas to help prepare the private equity firm's current urgent care group and the newly acquired group to integrate its operations, finances, and services.

- We performed an overall assessment of the transaction and of both groups, which revealed gaps and opportunities to streamline processes and systems.
- Our team worked with the acquirer to transform its internal financial reporting processes and controls as well as provided interim management support for critical role gaps.
- We identified opportunities to optimize and integrate both groups' EHR systems and claims reporting, streamline staffing redundancies for maximum productivity and improve documentation to enhance financial performance and the patient experience.

THE RESULT

- Now that the acquirer's operations, revenue cycle management and systems are optimized, it is poised for successful integration with the newly purchased urgent care clinics.
  - EHR and revenue cycle optimization efforts resulted in:
  - **3.7%** improvement in collection rate (**$10.4M** annualized net improvement)
  - **$8.2M** cash acceleration over baseline
  - **39%** reduction in days in A/R
  - **36%** reduction in A/R > 90 days
  - **27%** reduction in total AR

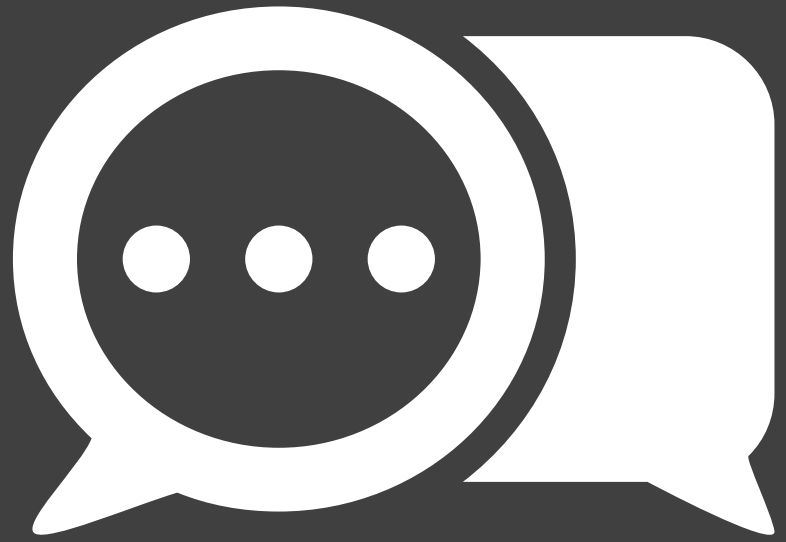


Discussion Question #6

Would you like to speak to a BDO professional about any of the following topics?

A	2023 Regulatory Changes
B	Revenue Cycle Optimization
C	Financial Improvement for PE-Backed Physician Groups
D	All the above
E	None of the above
F	N/A

Q&A



Thank You!

Conclusion

Thank you for your participation!

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Handouts:

Click the Handouts icon for helpful resources, including CPE information.

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**If you participated as part of a group, please allow additional time for CPE processing.*

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