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THE NEWSLETTER FROM THE BDO CENTER FOR HEALTHCARE EXCELLENCE & INNOVATION

BDO KNOWS HEALTHCARE

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PERSPECTIVE IN HEALTHCARE

By Steven Shill, CPA, The BDO Center for Healthcare Excellence & Innovation

A growing number of private equity investors are looking to take advantage of the booming market for behavioral health services, which includes companies providing long-term treatment for a broad scope of issues including depression, substance abuse and mental illness. The U.S. Department for Health and Human Services predicted that U.S. expenditure on mental health and substance abuse treatments would reach $239 billion by the end of 2014, up from $121 billion in 2003.

Observers are predicting continued strong growth for the sector. The Affordable Care Act has made it compulsory for new healthcare plans to cover these and other long-term rehabilitation treatments. Young people struggling with eating disorders or drug addiction are now covered on their parents' plans until the age of 26. And, thanks to the economic recovery, more people can afford the out-of-pocket expenses their plans do not cover. This means that many more people are able to get treatment who previously could not afford it.

At the same time, budget cuts to state-run facilities – some 4,500 psychiatric beds were eliminated between 2010-2013 – mean that more and more patients are being diverted to privately run treatment centers, the WSJ Private Equity Beat blog reports.

The stock markets are bullish on behavioral health companies. AAC Holdings, parent of American Addiction Centers, has seen its share value climb 70 percent since going public last October. In December, shares in behavioral health firms Acadia Healthcare Company and AAC Holdings were trading at 32 times and 56 times projected 12-month earnings, compared with 17 times for a broader range of healthcare companies, according to Thomson Reuters data.

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PERSPECTIVE IN HEALTHCARE

Investors are flocking to the fast-growing sector, although high demand is pushing up valuations and many assets may be overpriced. Waud Capital Partners-backed Acadia recently purchased CRC Health Group for $1.18 billion, more than 10 times its 2014 earnings of $115 million, the WSJ blog reports. Private equity firms that made acquisitions in recent years are taking advantage of the renewed demand to sell their assets. Bain Capital, the company that just made the $1.18 billion CRC sale, had purchased it for $723 million in 2006, according to Reuters.

Finding acquisition targets of a suitable size is also difficult. Addiction services providers in particular tend to be small, and the market is extremely fragmented. Many are run by religious groups, nonprofit organizations, or recovered patients who now run one or two centers. With over 14,500 specialized drug treatment facilities in the U.S., the largest operators have no more than a few dozen treatment centers, and the average operator has no more than 150 beds, Reuters Business Insider reports.

This level of fragmentation, mixed with high demand and a lack of sizable operators, makes the sector ripe for consolidation. Healthcare companies and private equity firms with existing investments are looking to snap up additional centers in order to benefit from efficiencies of scale.

The UK market is also proving attractive to acquirers, where long-term behavioral health services are often provided by privately run companies due to a lack of capacity within the state-run National Health Service. Universal Health Services recently acquired UK behavioral health firm Cygnet Health Care for $335 million. This followed Acadia's transatlantic acquisition of UK firm Partnerships in Care for $340 million last summer.

Steven Shill, CPA, is a Partner and National Leader of The BDO Center for Healthcare Excellence & Innovation. He can be reached at sshill@bdo.com. PErspective in Healthcare is a feature examining the role of private equity in the healthcare industry.

DEDUCING THE DEDUCTION: FINAL REGULATIONS CREATE COMPENSATION COMPLICATIONS

By Sara Hendrix, CPA, BDO USA

ON SEPTEMBER 23, 2014, THE IRS ISSUED FINAL REGULATIONS ON THE $500,000 LIMIT IMPOSED UNDER THE AFFORDABLE CARE ACT ("ACA"), ON THE DEDUCTION FOR COMPENSATION PAID BY A "COVERED HEALTH INSURANCE PROVIDER" (CHIP).

The final regulations provide critical guidance on several issues, including both the application of the controlled group rules for purposes of determining whether an entity is regarded as a CHIP, and rules for allocating compensation to a specific year of service (particularly in the case of compensation payable in a subsequent tax year(s)). Section 162(m)(6) of the Internal Revenue Code was enacted as part of the ACA in order to limit the compensation expense deduction available to certain health insurance providers that are regarded as CHIPs. For tax years beginning after December 31, 2012, an issuer of health insurance is treated as a CHIP if they receive 25 percent or more of their gross premiums from "minimum essential coverage" ("MEC"), generally defined as coverage that individuals are required to maintain to avoid incurring ACA penalties. This MEC includes any employer-provided health insurance coverage, individual market coverage, and governmental coverage (such as Medicare or TRICARE).

Adding to the complexity under these rules, the determination of whether a health insurance issuer is a CHIP can vary with each tax year as compensation and revenue streams change. The deduction limitation may apply in one tax period, but the entity may be exempt in subsequent or prior periods. And the exceptions to the rule are complex and cross tax years, applying to both current and deferred compensation. They also apply to tax years beginning Jan. 1, 2013, meaning some insurers will have to revisit past tax years and re-evaluate their liability.

The Financial Implications of CHIP Status

Company Y meets the definition of a CHIP for its 2015 tax year. During this tax year, Y pays Employee A $400,000, Employee B $700,000 and Employee C $900,000.

Since Y can deduct only $500,000 per employee, it loses the ability to deduct $600,000 in compensation. Assuming a combined federal and state tax rate of 40 percent, CHIP status increases Company Y's tax liability by $240,000.

Every entity sharing common control with a CHIP (defined by the Internal Revenue Code as being in the same "aggregate group") is also, by that association, subject to the compensation deduction limit. In addition, the $500,000 deduction limitation applies to compensation provided all employees, directors, and (in certain cases) independent contractors within the CHIP aggregate group, and not just the top-four highest compensated employees as under the $1M compensation limit imposed on public companies.

Common types of aggregate groups include parent-subsidiary entities, affiliated service groups or non-corporate entities under common control. As the distinction between healthcare provider and insurer blurs, it stands to reason that more hospitals and long-term care providers could find themselves subject to CHIP tax provisions if they provide insurance themselves or enter a common control arrangement with an insurer.

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DEDUCING THE DEDUCTION

By understanding the exceptions to Section 162(m)(6)and considering strategic compensation planning, insurers and those under common control can both limit their tax burden and retain more control over cash flow.

PLANNING AHEAD FOR CHIP STATUS

Each taxpayer that has the potential to be defined as a CHIP should perform a thorough evaluation of its revenue streams and compensation policies on an annual basis to ensure that they are prepared for the possible limitations that Section 162(m)(6) may provide.

Affected entities may be able to design base compensation, or long-term incentive and deferred compensation arrangements in order to avoid/minimize the deduction limit. One option includes spreading compensation out over a number of tax years. While deferred compensation is subject to the provision, an organization that knows it will fall under CHIP provisions one year but not the following may opt to defer bonuses or other compensation to limit its tax burden and retain control over cash flow.

UNDERSTANDING EXCEPTIONS TO CHIP STATUS

De Minimis Exception

The IRS provides an exception for de minimis premiums. Under this exception, an aggregate group that would otherwise be a CHIP is not subject to the compensation limitation if the premiums for minimum essential coverage received by all members of the aggregate group are less than 2 percent of the gross revenue of the aggregate group for the tax year. Further, the final regulations provide a "grace period" to permit entities to adjust and adapt to a change in their status as a CHIP, or a member of the aggregate group of a CHIP: The deduction limit will not apply in the first year that premiums exceed 2 percent of the gross revenue if the aggregate group qualified for the de minimis exclusion in the prior tax year.

Revenue Exceptions Not Considered Premiums

A health insurance issuer is defined as a CHIP only if it receives premiums from providing minimum essential coverage. Entities that are concerned about their potential CHIP status should examine all of their revenue streams with someone who understands the revenue exceptions.

1. Amounts received under an indemnity reinsurance contract and amounts defined to be direct services payments, for example, are not treated as premiums for purposes of Section 162(m)(6). Specifically, health insurance issuers may reinsure a portion of their risks by entering into indemnity reinsurance contracts with various reinsurers. The final regulations affirmed that premiums received under an indemnity reinsurance contract are not treated as premiums from providing health insurance coverage, provided that under the reinsurance contract (1) the reinsuring company agrees to indemnify the health insurance issuer for all or part of the risk of the loss and (2) the health insurance issuer retains its liability to the individual insured.

2. Some health insurance issuers enter into arrangements with third parties to provide, manage or arrange for the provision of services by physicians, hospitals or other healthcare providers. Under these arrangements, the health insurance issuer may pay compensation to the third party in the form of capitated, prepaid periodic or other payments for these services (referred to as "direct service payments"). The third party may also bear some or all of the risk in the event that the compensation is insufficient to cover the full cost of providing and managing these services.

The final regulations provide that these direct service payments made by a health insurance issuer are not treated as premiums for purposes of Section 162(m)(6), regardless of whether the third party is subject to healthcare provider, health insurance or other regulatory requirements under state law.

Compensation Subject to Limitation – Current and Deferred

The $500,000 compensation limitation applies to both current and deferred compensation paid to applicable individuals. Current compensation generally includes salaries or bonuses paid within 2½ months of year-end. Deferred compensation (referred to as "deferred deduction remuneration," or "DDR" under Section 162(m)(6)) is compensation that is deductible in a tax year(s) after the year in which the related services were performed, such as non-qualified deferred compensation, stock option compensation, long-term incentive compensation arrangements or severance.

The $500,000 compensation limit applies first to the current compensation received. If this current compensation is less than $500,000 for that tax period, the remaining amount is applied to any deferred compensation earned in that year. The final regulations provide complicated rules for assigning DDR to one or more years of service. DDR must be allocated to the tax years in which the services were performed, and the $500,000 compensation limit for a particular tax year is applied to the portion of compensation allocated to that year. In addition, the regulations allocate DDR to years of service differently, depending upon the type of compensation arrangement in issue. The method for allocating the compensation generally must be applied consistently for each type of compensation arrangement, and/or for each employee.

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BEST PRACTICES FOR EVALUATING CLINICAL STRATEGY

By Dr. David Friend, MBA, The BDO Center for Healthcare Excellence & Innovation

Healthcare providers must transform the way they approach healthcare delivery—then measure, innovate, refine and measure again to ensure they're having a maximum impact on the populations and key stakeholders served.

The healthcare industry is undergoing a complete paradigm shift. New reimbursement models, technological advancements, an aging population and changes mandated under healthcare reform have all combined to reshape the industry, placing tremendous pressure on healthcare organizations to adapt, cut costs and elevate the quality of care. As healthcare providers work to shift their focus from volume to value, the status quo is not sufficient.

To succeed in this new environment, healthcare organizations must develop strategies that will enable them to transform the way care is delivered. They must integrate their clinical services, information technology platforms and financial systems to ensure they are continually providing the right care, for the right amount of time, at the right place and for the right cost.

From a clinical perspective, the American Hospital Association describes integration as the means to facilitate the coordination of patient care across conditions, providers, settings and time to achieve care that is safe, timely, effective, efficient, equitable and patient-focused. This type of clinical integration is seen as essential to achieving the triple aim of producing better care for individuals, better health for populations and lower per capita healthcare costs. However, truly successful integration and coordination of clinical care is an extraordinarily complex logistical challenge that rivals the engineering achievements that helped build the space shuttle, Air Force One and the Stealth bomber. I understand the parallels first hand; before I became a physician, I helped run High Voltage Engineering and was a supplier to all three complex systems.

CAPABILITIES ASSESSMENT

As I reflect on both my engineering and clinical experience, I believe that to move toward more fully integrated models of care, hospitals and health systems must first understand where they are on the continuum of integration. To do so, healthcare organizations should start by assessing the community's healthcare needs within the context of their hospital or health system's responsibility to serve them. This analysis should be three-pronged, including:

- Community outreach to truly understand the current and future needs of the populations served
- An evaluation of the coordination of care across settings (providers, payers and patients) to determine where elements of the healthcare system are still operating in isolation and identify opportunities for better coordination across silos
- An assessment of the current points for patient access to ensure the necessary ambulatory, primary care, and home health and chronic disease management services are established to promote healthy behavior and reduce hospitalizations and emergency room visits for non-emergent and acute services.

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CLINICAL STRATEGY

A LOOK AT DELIVERY MODELS

After the initial assessment of current capabilities is completed, healthcare leaders should next establish the long-term goals of their hospital or health system, given the community's needs and within the context of healthcare reform. This goal-setting process requires healthcare leaders to first evaluate their organization's current care delivery models, looking specifically at their sustainability within the context of healthcare reform. Then, healthcare leaders must identify required future-state delivery models, considering the hospital or health system's desired:

- Financial position
- Market position
- Drivers of innovation
- Culture and workforce characteristics, including incentives
- Payment and reimbursement models, and
- Networks, partnerships and collaborations across the healthcare system

GAPS ANALYSIS

With the analysis of both current and future state completed, healthcare leaders should proceed to determining gaps that must be filled to achieve their desired future-state delivery models. This gap analysis process will inform the critical next step: creating a roadmap to guide implementation and transformation toward future-state delivery models, starting at the desired future state and working backwards.

This roadmap should not only address clinical integration within the hospital, but also areas including:

- Cost structure, which must be fully aligned with the long-term vision and future strategy of the hospital or health system
- Information technology infrastructure, which is critical to delivering fully coordinated, quality care, given the information sharing and data analytics new technology platforms enable
- Physician engagement, which is crucial as the core of this transformation must be clinical and therefore physician-led
- Clinical guidelines to help caregivers assess their effectiveness in delivering appropriate, quality care
- Performance and quality metrics that are standardized across providers to ensure alignment with long-term objectives
- Legal and regulatory considerations, which must be addressed when moving toward more fully integrated care models. These include antitrust and anti-kickback laws and IRS provisions regarding tax-exempt organizations, among others.
- The full continuum of care, which must be coordinated between inpatient, ambulatory and post-acute providers

While the transformation of clinical strategy and care models is among the most urgent of the needs facing healthcare providers today, it is critical that, during the implementation process, healthcare organizations continue to also focus on their day-to-day operations. This will ensure they do not lose any gains that have been made in terms of the transition period, cost structure alignment and performance improvement. Often this can be accomplished by having dedicated resources to help drive the required changes, while other resources focus solely on day-to-day operations.

A significant gap exists between the quality of care the U.S. healthcare system is capable of achieving and the quality of care it delivers. To bridge this gap, healthcare providers must continue to transform the way they approach healthcare delivery—then measure, innovate, refine and measure again to ensure they're having a maximum impact on the populations and key stakeholders served. While this is an extraordinarily difficult challenge, it has been surmounted before in other industries. Healthcare systems should seek to learn from other industries with prior experience, adapt that knowledge to today's challenges, harness new technology and create world-class integrated care for all of us.

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DID YOU KNOW...

According to market intelligence group ***Irving Levin Associates***, healthcare mergers and acquisitions in Q4 of 2014 saw a 120 percent gain in dollar amount over Q3 of 2014.

The ***Department of Health and Human Services*** says that of the Americans who reach age 65, 70 percent will require some type of long-term care.

Amid changing reimbursement models, ***Research and Markets*** predicts the U.S. revenue cycle management outsourcing market will grow by 15 percent over the next five years.

A study conducted by the ***University of Pennsylvania*** and the ***Urban Institute*** finds that the increase in Medicaid reimbursement for primary care providers is linked to a 7.7 percentage point increase in new patient appointment availability without longer wait times.

In the United States, a report by advocacy group ***Mental Health America*** states that 42.5 million, or 18.19 percent of the adult population, have a mental health issue.

StartUp Health, a digital healthcare accelerator, reports that new funding doubled in the digital space from 2013 to 2014 to approximately $6.5 billion.

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A COMMERCIALLY REASONABLE DEFENSE AGAINST REGULATORY SCRUTINY

By Joshua Lefcowitz, CPA/ABV/CFF, CVA, CFE, ASA, and Kristin Fox, ASA, BDO USA

When contemplating a transaction or agreement, healthcare decision-makers, including executives, physicians and hospital administrators, are obligated to ensure the proposed arrangement is commercially reasonable or face exposure from a regulatory perspective.

In a climate of increased consolidation, some healthcare decision-makers may believe that as long as they obtain a fair market value (FMV) analysis at the time of the transaction, they are protected against potential scrutiny from regulators. In reality, parties to healthcare transactions are increasingly vulnerable. This is tied to the increased rate of mergers and acquisitions, a changing and more complex regulatory environment, and the increased frequency of qui tam occurrences in recent years in the healthcare industry. Obtaining a commercial reasonableness analysis can be an effective means of combatting this vulnerability.

BASICS OF COMMERCIAL REASONABLENESS

There is no one generally accepted definition of commercial reasonableness. However, there is guidance that can be referenced. The 2006 American Law Institute states, "Each financial and contractual connection between hospitals and physicians should be scrutinized to ensure that goods and services changing hands are being provided at FMV, and **at a level no more than necessary for the business purpose of the arrangement.**" Various federal agencies and regulations have definitions that reflect the concept that there must be an absence of any potential referrals included in the assessment of commercial reasonableness.

NUTS AND BOLTS OF COMMERCIAL REASONABLENESS

The first step in determining whether a transaction is commercially reasonable is determining whether the transaction was consummated at FMV and that there was no payment for referrals and that the basis for the arrangement is not to drive referrals to the organization. Next, a more in-depth examination of all aspects of the arrangement must be performed to ensure the transaction is both legally permissible and accomplishes a business purpose. Finally, a quantitative analysis, also known as a financial feasibility test, must be performed to determine whether the transaction is commercially reasonable.

FAIR MARKET VALUE (WITHOUT REFERRALS)

At the core of a commercial reasonableness analysis with respect to a merger or acquisition is a valuation of assets or stock performed under the FMV standard of value, with certain adjustments. A commercial reasonableness analysis assumes that the acquired entity has a highest and best use as a going concern. For purposes of determining FMV, the income approach should generally be considered. Within the context of the income approach analysis, we are able to specifically show the removal of any cash flow derived because of referrals expected to be received as a direct result of the transaction.

QUALITATIVE ANALYSIS[1]

As a part of the analysis, we ask whether or not the arrangement accomplishes a business purpose. In order to assess the arrangement we should analyze the following aspects:

Necessity – Are the items and services obtained necessary to achieve a legitimate business purpose, apart from business referrals?

Nature and Scope – Are the costs reasonable in relation to the services performed and goods provided?

Enterprise/Organizational Elements – Was the consideration paid for the subject property interest "a sensible, prudent business agreement"?

Quality, Comparability and Availability – Are the nature and quality of the services, assets and enterprises included in proposed transactions reasonably necessary?

Ongoing Assessment, Management Control and Other Elements – Are there other elements of the transaction that may not fit into the previously discussed categories?

QUANTITATIVE ANALYSIS

In additional to the assessment of qualitative aspects of the arrangement, we should also perform quantitative analysis, which shows the bona fide nature of the business arrangement and determines whether or not the financial terms of the anticipated transaction reflect terms that would be reached by other prudent investors without consideration of any referrals that may be gained.

Due to the complexity of healthcare transactions and relationships, it is important that a deep dive is taken during the due diligence process. Professionals must first obtain a summary of relationships and understand who the physician and vendor relationships are with and what services are being offered. A thorough investigation of revenue and expenses must be made, and considerations such as owners' compensation at FMV must be understood. During the process, the analyst must examine the services being offered and answer questions related to compensation arrangements and necessity of services.

Oftentimes a transaction that was considered to be consummated at FMV may not be able to be considered commercially reasonable. This is because FMV focuses more heavily on range of dollars paid or the financial aspects of the transaction, while commercial reasonableness analyses scrutinize every

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REGULATORY SCRUTINY

aspect in isolation as well as the arrangement in its entirety.

Rendering a commercial reasonableness opinion requires that a specific set of core competencies be mastered by the valuation analyst, apart from, but related to, the more traditional knowledge, skill set and experience required in providing the more traditional appraisal activity of rendering FMV opinions related to the appraisal of the enterprises, assets and/or services being transacted. [2]

CONCLUSION

Commercial reasonableness analyses are an increasingly important requirement given the increased consolidation among healthcare provider organizations and increased enforcement from regulators. Commercial reasonableness analyses can be viewed as an in-depth critique of every aspect of the transaction, including but not limited to relationships between parties to the arrangement, how revenues are earned and expenses are determined within a healthcare entity to ensure relevant regulations are not violated.

A version of this article first appeared in Thomson Reuters' "Valuation Strategies." Reprinted with permission.

[1] Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services," By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, Hoboken, NJ: John Wiley & Sons Inc., 2014, p. 939-958

[2] Healthcare Valuation in "The Financial Appraisal of Enterprises, Assets, and Services" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, John Wiley & Sons Inc., 2014, p. 930

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FOUR STEPS NONPROFIT HOSPITALS SHOULD TAKE TO HELP RETAIN THEIR TAX-EXEMPT STATUS

By Laura Kalick, JD, LLM, The BDO Center for Healthcare Excellence & Innovation

NEWLY FINALIZED IRS REGULATIONS FURTHER DISTINGUISH THE PRACTICES OF TAX-EXEMPT HOSPITALS FROM THOSE OF FOR-PROFIT HOSPITALS.

While these new provisions are not applicable until tax years beginning after Dec. 29, 2015, hospitals are encouraged to examine their own policies and pursue compliance this year: In considering whether to revoke tax-exempt status following a compliance breach, the IRS will consider all relevant efforts the hospital has made to identify and address failures *before* the IRS discovers them.

The new provisions are outlined in Section 501(r) of the Internal Revenue Code. They provide that a tax-exempt hospital:

- Must conduct a community health needs assessment at least once every three years and adopt an implementation strategy to meet the needs identified;
- Must establish a written financial assistance policy (FAP) and a written policy relating to emergency medical care;
- Must not use gross charges, and must limit amounts charged for emergency or other medically necessary care provided to FAP-eligible people, to not more than the amounts generally billed to individuals who have insurance covering such care;
- Must make reasonable efforts to determine whether an individual is FAP-eligible before engaging in extraordinary collection actions.

These are in addition to 501(c)(3) requirements and to meeting the community benefit standard of Rev. Rul. 69-545. Noncompliance can result in revocation of the hospital's tax-exempt status. The implications of these new provisions impact departments beyond those typically associated with tax and accounting, necessitating the awareness and understanding of hospital board members and departments such as marketing and community relations that may not typically be involved in IRS discussions. These rules apply even if a hospital operates a facility through a partnership or limited liability company where it has an ownership stake.

SHARE COMMUNITY NEEDS WITH THE COMMUNITY

The community health needs assessment conducted every three years (CHNA) must, per IRS provisions, be made widely available to the public in order to incorporate input from representatives of a broad cross section of the community. Once an implementation strategy has been developed to meet the community health needs identified, that report, too, must be made "widely available to the public" in accordance with specific criteria. This standard, the same applied to Form 990 public availability, can be satisfied if the CHNA is posted online. While private organizations that make all Forms 990 available to the public exist, no such service exists for CHNAs, putting the publicity onus on provider organizations themselves. Paper copies must also be publicly available upon request.

PROVIDE TRANSPARENCY INTO FAP ELIGIBILITY

Tax-exempt hospitals must have a written FAP that includes:

- Eligibility criteria and whether assistance includes free or discounted care;
- The basis for calculating amounts charged to patients;
- How to apply;
- Actions the organization may take in the event of non-payment, including collections action and reporting to credit agencies, unless a separate billing and collections policy is available;

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FOUR STEPS

- Any other sources of information used to determine FAP eligibility;
- A list of any providers, other than the hospital, that deliver emergency or other medically necessary care in the hospital and which providers are covered by the hospital's FAP and which are not.

Even though there may be other discounts, the IRS will only view the discounts specified in a hospital's FAP (and, therefore, subject to the "amounts generally billed" limitation) as a community benefit.

The threshold for "widely publicizing" the FAP is higher than the "widely available" threshold applied to the CHNA. To meet that threshold, the hospital must:

- Make the FAP, application form, and plain language summary widely available online;
- Make free paper copies of the same available upon request, both by mail and in public locations in the hospital, including, at a minimum, in the emergency room (if any) and admissions areas;
- Notify the community about the FAP so that it reaches those who are most likely to need financial assistance; and
- Notify and inform persons hospital patients by:
  - Offering a paper copy of the plain language summary upon intake or discharge;
  - Including a conspicuous written notice on billing statements, including telephone numbers and the website where additional information and documents may be obtained;
  - Setting up conspicuous displays about the FAP in public locations in the hospital, including, at a minimum, the emergency room (if any) and admissions areas.

The final regulations also require that FAP documents be translated into every language spoken by people with limited English proficiency where those speakers make up at least 5 percent of the population served, or 1,000 people, whichever is less. The threshold outlined in the proposed guidelines now followed by many hospitals is 10 percent.

LIMIT HOW MUCH FAP PATIENTS ARE CHARGED

FAP-eligible patients cannot be charged gross charges; the hospital must limit its charges for emergency or medically necessary care to not more than the "amounts generally billed" (AGB) to individuals with insurance covering that care. The AGB rate cannot merely be a percentage discount off the charge master rates, but must instead be based on one of the two specific methods dictated by the regulations. Only one method can be used at a time, but different hospitals operated by the same organization may choose to use different methods to get a better rate, and a hospital may change the method it uses to determine AGB at any time. Nonemergency elective services could be billed at gross charges or a rate higher than AGB.

PAUSE AND EVALUATE BEFORE INITIATING DEBT COLLECTION EFFORTS

Nonprofit hospitals cannot engage in specific "extraordinary collection actions" until they have made "reasonable efforts" to determine whether an individual is FAP eligible, the latter being defined, in part, as giving patients eight months (240 days) after the first post-discharge bill to apply for financial assistance.

Extraordinary collection actions include:

- Selling an individual's debt;
- Reporting adverse information to credit agencies;
- Deferring or denying, or requiring a payment before providing, medically necessary care because of a person's nonpayment of a previous bill for care covered under the hospital's FAP ;
- Actions that require a legal or judicial process

HEAD OFF FUTURE THREATS TO TAX-EXEMPT STATUS NOW

A hospital that fails to meet the requirements of section 501(r) may have its section 501(c)(3) status revoked and its income subject to taxation. While many of the provisions enumerated will require time to implement, and the familiarity of departments that touch the hospital's website, community outreach, accounting, and other aspects, they can also be put into motion immediately in preparation. The time for hospitals to take action is now.

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NEW YEAR'S RESOLUTIONS: TIME TO GIVE YOUR PHYSICIAN PRACTICES A COMPLIANCE CHECK-UP

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

As hospitals have acquired a growing number of physician practices in recent years, they've also acquired new compliance problems that often fly under the radar. There is a dizzying array of rules and regulations with which healthcare providers must be compliant, and claims submissions are among the most imperative and problematic.

These compliance activities are often more "routine," and therefore don't always get the time and attention they deserve. But the problems that can arise when things go wrong can have a significant impact on your organization. Documentation matters for everything from facility claims to the medical necessity for supplies and testing. There are two mind-sets to achieving proper compliance for physician practices: the more proactive "well visit" approach or the reactive "sick visit" approach.

THE WELL VISIT APPROACH

Just as patients are encouraged to see their physicians routinely for well-care visits, claims must receive regular checkups during the good times, as well, to ensure all services are being performed, documented, coded and billed correctly. If a problem is identified, appropriate actions can be taken immediately to correct it and treat the issue. The process also serves as a tool to keep the staff up-to-date on pertinent guidelines and regulations that affect them and their jobs. While there may be conflicting views on the efficacy of well care for people, there is no doubt to the efficacy of a well-crafted and implemented compliance plan. They work, if you allow them.

THE SICK VISIT APPROACH

All too often, it's the problem visit that we see not only in the treatment of our patients, but also in dealing with various compliance issues.

With the implementation of higher deductibles and copays, we are seeing more patients delay dealing with problems until they have multiple issues, which become more complex when they finally do present for treatment.

The same can be said of compliance issues. Many providers operate under the false impression that since their services were paid, their coding is correct. This is a common misconception in healthcare. It's true that a paid claim means no issues were triggered by the payer, but that doesn't mean you don't have a coding accuracy problem.

Some insurance carriers are more diligent about providing clear written direction around reimbursements, but ultimately it's a healthcare provider's responsibility to understand its business operations, the law and the importance of monitoring compliance.

URGENCY IS OF THE ESSENCE

Between reimbursement decreases, increases in regulatory requirements, and the general overworked nature of the healthcare industry, healthcare providers are becoming "sicker" and the problems more complex as compliance issues are left to linger. And too many organizations are seeking treatment when it's too late.

The government is becoming more aggressive in targeting fraud. The Affordable Care Act (ACA) included language requiring that provider practices have compliance plans as a condition of enrollment with the governmental payers.[1] As of the publication date of this article, the government has not defined what must be included in that compliance plan, or the official effective date by which providers must comply; what is clear is that they intend to take a more prevenative approach to fighting abuse versus the traditional retrospective pay and chase model.

An active and effective compliance plan is essential to detecting and correcting errors before they become ingrained, complicated issues that eat up precious time and resources to resolve. Implementing cost effective processes may be a challenge, but the financial impact of the consequences can be much more significant. An ounce of prevention really is worth a pound of cure.

[1] The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), Section 6401: Changes to Medicare and Medicaid Provider and Supplier Enrollment Process

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MARK YOUR CALENDAR...

MARCH 2015

March 11-13
2015 VA-DC HFMA Spring Education Conference*
Hilton Richmond Hotel & Spa/Short Pump
Richmond, Va.

March 16-19
Congress on Healthcare Leadership
Hilton Chicago/Palmer House Hilton
Chicago

March 22-25
The 12th Annual World Health Care Congress & Exhibition
The Marriott Wardman Park Hotel
Washington, D.C.

March 31-April 2
NIC 2015 Capital & Business Strategies Forum*
Hilton San Diego Bayfront
San Diego

APRIL 2015

April 8-10
Patient Experience Conference 2015
Omni Dallas Hotel
Dallas

April 12-16
HIMSS Annual Conference
McCormick Place
Chicago

April 20-22
National Council for Behavioral Health NATCON Conference
Gaylord Palms Resort & Convention Center
Orlando

MAY 2015

May 10-13
LTC 100*
The Greenbrier
White Sulphur Springs, W.Va.

May 28-29
iHealth 2015 Conference
Boston Park Plaza Hotel
Boston

* Indicates that BDO representatives will be present at conference.

About The BDO Center for Healthcare Excellence & Innovation

The BDO Center for Healthcare Excellence & Innovation unites recognized industry thought leaders to provide sustainable solutions across the full spectrum of healthcare challenges facing organizations, stakeholders and communities. Leveraging deep healthcare experience in financial, clinical, data analytics and regulatory disciplines, we deliver research-based insights, innovative approaches and value-driven services to help guide efficient healthcare transformation to improve the quality and lower the cost of care. For more information, please visit www.bdo.com/healthcare.

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