Changes in Healthcare

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The Health Care Market is Changing

• Affordable Care Act
• Employer/Patient Involvement
• Value Based Programs
  • Value Based Purchasing
  • Readmissions
  • Hospital Acquired Conditions
• ACOs
• Bundled Payments
The Health Care Market is Changing

• These changes will change the way all providers operate
  • Rural
  • Urban

Affordable Care Act

• The impact is not going away

• Result
  • Increased coverage
    • Newly covered patients in the market
    • Confused patients in the market
  • Impact of Medicaid expansion varies
Affordable Care Act – Medicaid Expansion

Current Status of State Medicaid Expansion Decisions

NOTES: Current status for each state is based on KCMC tracking and analysis of state executive action. *MA, IA, IN, MT, AR and MI have approved Section 1115 waivers. Coverage under the MI waiver went into effect 1/1/15, but it has transitioned coverage to a state plan amendment. Coverage under the MI waiver went into effect 1/1/2016. LA’s Governor Edwards signed an Executive Order to adopt the Medicaid expansion on 1/12/2016, but coverage under the expansion is not yet in effect. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion. See source for more information on the states listed as “adoption under discussion.”


Affordable Care Act – Hospital Closures Since 2010

Employer/Patient Involvement

• Employers
  • Increased out of pockets
  • Narrow networks

• Increased out of pockets
  • Push responsibility to help control cost to employees

Employer/Patient Involvement

• Narrow networks
  • Reduced cost to employees for using providers that provider advantageous pricing and/or demonstrate value
  • Walmart
    • No-cost knee and hip-replacement surgeries
      • Johns Hopkins Bayview Medical Center
      • Kaiser Permanente Orange County Irvine Medical Center
      • Mercy Hospital (Springfield, Missouri)
      • Virginia Mason Medical Center
    • No cost
      • No deductible/coinsurance
      • Travel
      • Lodging
      • Living expense
      • Includes caregiver
Employer/Patient Involvement

- Patients have become engaged
  - Cost
  - Access/Convenience

- Cost
  - Higher deductibles
  - Must be able to provide estimates and payment expectations/options

- Access/Convenience
  - Means something different to each individual

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### What Does “Convenience” Mean to You?

<table>
<thead>
<tr>
<th>Convenience</th>
<th>18-29</th>
<th>30-49</th>
<th>50-64</th>
<th>65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extended Hours</td>
<td>Clinic is open 24/7 highest ranked convenience attribute</td>
<td>Time to First Available</td>
<td>Ancillaries On-site</td>
<td></td>
</tr>
<tr>
<td>Access</td>
<td>After-Hours Access</td>
<td>Weekend Availability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Value</td>
<td>Eliminating Out-of-Pocket Charges</td>
<td>Convenience &gt; Free</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reputation</td>
<td>These cohorts cared less about reputation than the 65+ cohort—no reputation factors appeared in their top 20 attributes. Their highest reputation factor was Clinic’s patient satisfaction survey scores are in top 10% for my area</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality</td>
<td>Cutting Edge Technology and Provider Credentials</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Advisory Board Presentation: Blueprint for Growth 2020; 2014 Primary Care Consumer Choice Survey, Marketing and Planning Leadership Council
Disruptive - Technologies

Employer / Patient Involvement

- Access/Convenience
  - Addressing convenience will require changes in the way we operate
    - Hours
    - Approach
Value Based Programs - Coming

- Value Based Purchasing
- Readmissions
- Hospital Acquired Conditions
- Bundled Payments
- Accountable Care Organizations

Hospital Value Based Payments

- Takes payments from all and redistributes based on calculated value
- Only applies to PPS hospitals........today
- All hospitals should monitor value based payment programs
Value Based Purchasing Reductions to Providers

- FY 2013: +1.00%
- FY 2014: +1.25%
- FY 2015: +1.50%
- FY 2016: +1.75%
- FY 2017: +2.00%

Value Based Purchasing Domain Weighting

- Clinical Process of Care:
  - 2013: 70%
  - 2014: 45%
  - 2015: 30%
  - 2016: 20%
  - 2017: 20%

- Patient Experience:
  - 2013: 30%
  - 2014: 30%
  - 2015: 30%
  - 2016: 30%
  - 2017: 30%

- Outcomes:
  - 2013: 30%
  - 2014: 30%
  - 2015: 30%
  - 2016: 30%
  - 2017: 30%

- Efficiency:
  - 2013: 10%
  - 2014: 10%
  - 2015: 10%
  - 2016: 10%
  - 2017: 10%

- Safety:
  - 2013: 10%
  - 2014: 10%
  - 2015: 10%
  - 2016: 10%
  - 2017: 10%

- Clinical Care:
  - 2013: 10%
  - 2014: 10%
  - 2015: 10%
  - 2016: 10%
  - 2017: 10%
Readmission Penalty Reductions

- Up to a 3% reduction!
- Only applies to PPS Hospitals.....today
- Keep adding the number of conditions that qualify
- Net saver for CMS

<table>
<thead>
<tr>
<th></th>
<th>% of Hospitals Penalized</th>
<th>Avg Hospital Penalty</th>
<th># of Hospitals Penalized</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S.*</td>
<td>-</td>
<td>.63%</td>
<td>2,610</td>
</tr>
</tbody>
</table>

* 39 hospitals received the maximum penalty

Hospital Acquired Conditions (HAC) penalty

- FY 2015 a 1% penalty kicks in
- Only applies to PPS hospitals.......today
- 721 Hospitals are affected this first year
- CMS assessed rates of 10 patient injuries at hospitals
  - Blood stream infections
  - Patient falls
  - Bed sores
  - Urinary tract infections
  - Collapsed lungs
  - Cuts that occur during or after surgery
  - Blood clots
- Net saver for CMS!
Bundled Payments

• Set price for a pre-defined episode of care
• Advantages
  • Simplified, single payment
  • Discourages unnecessary care
  • Predictable price
• Most common services so far:
  • Surgery (Orthopedic, General)
  • Obstetrics

Bundled Payments

• New CMS Program
  • Comprehensive Care for Joint Replacement
    • 67 Metropolitan Statistical Areas (MSA’s)
      • Mandatory
      • No downside in year 1
    • Bismarck was one of the 67 MSA’s identified
    • Strategies appear to include a significant focus on post-acute services
      • Swing Bed – potentially significant impact to CAHs
      • Nursing Homes
      • Home Health
Accountable Care Organizations (ACOs) – Definition (Wikipedia Definition)

An accountable care organization (ACO) is a healthcare organization characterized by a payment and care delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients. A group of coordinated health care providers forms an ACO, which then provides care to a group of patients. The ACO may use a range of payment models (capitation, fee-for-service with asymmetric or symmetric shared savings, etc.). The ACO is accountable to the patients and the third-party payer for the quality, appropriateness and efficiency of the health care provided. According to the Centers for Medicare and Medicaid Services (CMS), an ACO is "an organization of health care providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it."

ACO’s

- Pioneer ACO’s
- Shared Savings ACO’s
- Advance Payment ACO
- Next Generation ACO
- NRACO

- Commercial/Private ACO’s
ACO’s

- Models vary in the incentive and penalties
- Medicare Shared Savings Model appears to be most common in rural settings

Shared Savings ACO’s

- Rewards ACOs that lower their growth in health care costs while meeting performance standards on quality
- Two models
  - One-sided
  - Two-sided
Shared Savings ACO’s

- One sided model
  - Savings only
  - Sharing rate up to 50%
  - Based on quality performance
  - Up to 10% of benchmark

Shared Savings ACO’s

- Two models
  - Savings and losses
  - Sharing rate up to 60%
  - Based on quality performance
  - Savings
    - Up to 15% of benchmark
  - Losses
    - 5% in first year
    - 7.5% in second year
    - 10% in third year
Shared Savings ACO’s

- The opportunities are in the data
  - Wellness
  - Practice Patterns
  - Partners/Referral Sources

Medicaid ACO’s

- Medicaid programs emerging
- Anticipate continued growth
How Will This Change How We Operate?

- Revenue cycle
- Relationships
- Services
- Costs
- Data

Revenue Cycle

- We must develop a pricing strategy that is transparent in the industry
  - Charges
  - Estimates

- Robust up front collection programs that are followed will be required to provide needed cash flow
Relationships

• Primary care providers will have significant input on revenue stream
  • Strong relationships
    • Employment
    • Contracted
  • Aligned incentives and engagement
    • Compensation
    • Decision making
    • Board involvement
  • Communication

Services

• Volumes will be at risk in a population health environment

• Opportunities to maintain/improve volumes
  • Wellness services
    • Affects quality scores
    • Early identification of issues
      • Issues that can be handled locally
    • Typically lower out of pockets
    • Patient satisfiers
Services

• Opportunities to maintain/improve volumes
  • Wellness services
    • Alcohol Misuse Screening and Counseling
    • Annual Wellness Visit
    • Bone Mass Measurements
    • Cardiovascular Disease Screening Tests
    • Colorectal Cancer Screening
    • Counseling to Prevent Tobacco Use
    • Depression Screening
    • Diabetes Screening
    • Diabetes Self-Management Training
    • Glaucoma Screening

• Opportunities to maintain/improve volumes
  • Wellness services
    • Hepatitis B Virus Vaccine and Administration
    • Hepatitis C Virus Screening
    • HIV Screening
    • Influenza Virus Vaccine and Administration
    • Initial Preventative Physical Examination
    • Intensive Behavioral Therapy for Cardiovascular Disease
    • Intensive Behavioral Therapy for Obesity
    • Lung Cancer Screening and Annual Screening for Lung Cancer with Low Dose Computed Tomography
    • Medical Nutrition Therapy
    • Pneumococcal Vaccine and Administration
Services

• Opportunities to maintain/improve volumes
  • Wellness services
    • Prostate Cancer Screening
    • Screening for Sexually Transmitted Infections and High Intensity Behavioral Counseling to Prevent STIs
    • Screening Mammography
    • Screening Pap Tests
    • Screening Pelvic Examination
    • Ultrasound Screening for Abdominal Aortic Aneurysm

• Other
  • Advanced Care Planning
  • Transitional Care Management
  • Chronic Care Management
Services

- Opportunities to maintain/improve volumes
  - Market Share
    - Address patients receiving services elsewhere
    - Typically much larger volume than expected
  - Market studies
  - Community Health Needs Assessment
  - Access/Convenience issues

Costs

- Costs per unit of service are going to have to be managed more than ever before

- Labor and other
  - Salaries and benefits are the greatest cost
  - Challenge “minimum staffing” arguments
  - Think outside the box
  - Fixing processes is a key component
  - Need to implement and manage benchmarking program
Costs

- Labor management
  - Various date sources
    - External
      - Trade organizations
      - Research studies
      - Proprietary
    - Internal
      - Detailed study
      - Historical data

Costs

- Labor management
  - External data
    - Greatest benefit
      - Externally derived
      - Based on best practices
    - Greatest challenge
      - Difficult to access – costly
      - Methodology is often challenged
        - How data gathered
        - We are different
Costs

• Labor management
  • Internal data
    • Takes time to develop
    • Provides historical data and trending
    • Only includes your data
    • Recommend 5 year trending
      • Only use productive hours

• Labor management
  • Ultimately may use both internal and external data
    • External data to manage against peers
    • Internal data to monitor trends and reduce resistance
  • Example
    • Benchmark = 10 hours per statistic
Costs

• Labor management is about more than completing mathematical calculations
  • Processes are key
  • Cannot usually reduce resource utilization without updating the processes in the organization
  • Work smarter, not harder

Costs

• Not all departments will hit benchmarks each month

• Most facilities would experience significantly better financial performance if they could just get the majority of their departments to operate at the best historical levels of performance
The Health Care Market is Changing

• Multiple forces will require us to look at things differently

• Strategies from the past will not be enough for the future

• Early adopters will have the greatest opportunity for success
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Questions?

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Thank You!

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