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THE NEWSLETTER FROM THE BDO CENTER FOR HEALTHCARE EXCELLENCE & INNOVATION

BDO KNOWS HEALTHCARE

HOW BUNDLED PAYMENTS WILL REDEFINE VALUE IN HEALTHCARE: A Primer for Investors

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

The healthcare market's shift to value-based reimbursements is well underway, with the Centers for Medicare and Medicaid Services (CMS) steering the ship.

CMS has been aggressively rolling out initiatives to support its goal of tying 85 percent of traditional Medicare payments to quality or value by the end of 2016. As further evidence of the payment shift, the Department of Health and Human Services announced on March 3, 2016, that 30 percent of all Medicare payments were being delivered to providers through "alternative payment methods," exceeding the stated goal of achieving that threshold by the end of 2016. These payments totaled $117 billion of the $380 billion projected fee-for-service payments in 2016.

One of the most understated game changers is set to roll out in April this year: CMS' first mandatory bundled payment program. The program mandates that care is considered, delivered and measured as an "episode," not as a fragmented array of services. The "episode" approach, including a range of services in a single "bundle," is a major shift in how care is managed and reimbursed, impacting, most significantly, decisions about where and when patient care is delivered.

While the first mandatory bundled payment initiative is fairly narrowly focused, it will have a significant impact throughout the post-acute provider space, changing business

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models and the competitive landscape. With additional mandatory bundled payment programs expected to follow, it's critical for investors to understand how bundled payments are changing care delivery and the broader financial impact.

AN OVERVIEW OF BUNDLED PAYMENTS

The movement toward bundled payments has been around for a while, beginning with the inpatient prospective payment system in 1983, leading to the Bundled Payment for Care Improvement program (BCPI), which in October 2015 reported more than 1,600 voluntary participants. However, this year marks the first time that CMS is making bundles mandatory via its Comprehensive Care Joint Replacement Model (CJR), which holds hospitals responsible for all the costs, processes and outcomes for Medicare patients' hip and knee replacement surgeries within 90 days of the initial hospitalization. Hip and knee replacements are the most common inpatient surgeries for Medicare beneficiaries, and recovery and rehabilitation can be lengthy; therefore, the CJR model is a critical test of whether bundles will succeed as a method to control costs and increase quality of care. The five-year program starts April 1, 2016, affecting 800 hospitals in 67 metropolitan statistical areas (MSAs).

CMS will calculate and establish a bundled payment price specific to each provider. The provider's price becomes increasingly tied to regional performance each year until, after five years, the bundle price is the regional price. The quality of treatment and aggregate spending performance over the course of the 90-day period will dictate whether the hospital owes money or will receive additional payment from Medicare. The bundled payment model provides a real incentive for hospitals, physicians and post-acute care providers to collaborate on the best clinical process and most cost-effective resources for patients after hospital discharge.

To further stress the importance of quality in the equation, Medicare will tie payments to quality reporting under the CJR model. In an additional acknowledgement to quality, CMS announced that it is waiving the three-day stay requirement for Skilled Nursing Facility (SNF) placement, as long as the patient is discharged to a SNF with a Medicare Star Rating of 3 or higher.

THE RIPPLE EFFECT

This singular reimbursement change forces hospitals to re-think their entire approach to caring for hip- and knee-replacement patients. For the first time, hospitals have both the responsibility and incentive to help manage what happens to patients *outside the hospital walls*. Realizing clinical and financial success under this new payment and incentive model will require a more coordinated effort between hospitals and post-acute care providers, involving sharing data and analytics and developing gain sharing agreements and compliance systems to ensure the model's guidelines are met.

CJR will push hospitals toward a deeper evaluation of potential post-acute care providers, examining a range of factors including clinical processes, length of stay and readmission rates. These analyses will provide insights that will allow hospitals to work with narrower networks of partners to whom the patient's clinical processes are entrusted. SNFs and Inpatient Rehabilitation Facilities may see profound changes in referral patterns as a result. While CMS' three-day stay requirement waiver will not be implemented until 2017, hospitals are beginning to see star ratings of SNFs as part of their network evaluation. Under the waiver, 34 percent of the nursing home market (the percentage with Star Ratings of 1 or 2) is automatically eliminated as an option for early discharge based on their rating alone. And that's just the baseline. Business will plummet for many low-performing SNFs.

SNFs will face new competitive factors as well. Under the CJR model, nursing homes won't just be competing against other nursing homes for hip- and knee-replacement business; they will also compete with home care agencies and individual ambulatory rehabilitation practices. As hospitals evaluate the best patient care model under these new payment criteria, it's possible they will completely bypass nursing home care for some patients, opting instead to keep them in the hospital until they are ready for a home health agency or referring patients directly to outpatient rehabilitation services.

Still, why should such a small part of the market be so meaningful in the big picture?

The healthcare market closely tracks CMS trends; where CMS goes, commercial payers are soon to follow. In addition, CJR is a pilot program. As the results start to come in, it's quite likely that CMS will test mandatory bundled payments in other areas, as well.

SINK OR SWIM?

Change invites risk but, in the current healthcare environment, those who refuse to try new approaches are taking the biggest risks.

Hospitals that choose to incur a penalty (and can afford to pay it) instead of expending the time and resources to make the necessary changes that the CJR model requires are making a dangerous gamble. In the short-term, their inaction might yield a better financial outcome for the hospital. However, the regional price for a knee- and hip-replacement will drop as the CJR program progresses. Once those hospitals decide it's time to catch up, they'll be chasing a rapidly regressing market cost, potentially losing out on millions in reimbursements.

For nursing homes, change is equally—if not more—critical. Low performers risk not only losing business, but falling entirely out of some hospitals' networks. As hospitals increasingly use star ratings as a key factor in their decisions about discharging patients, investors must understand and take note of how the system works and how assets in their portfolio may be affected.

Medicare's Star Rating system is a forced ranking, so a certain percentage of the market must fall under each star level. In other words, there is no status quo; facilities with three stars are at high risk, as they can theoretically be knocked down at any time by a two-star facility moving up the ranks. In this environment, there must be a continuous effort to improve a facility's star rating. But star ratings don't necessarily tell the entire

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story; specific market dynamics will play an important part of a facility's success. In several major service areas, no three-star or above SNFs exist. Thus, a two-star facility might still be the best available option, after considering other factors such as regional competition and population insights.

STAYING ON TOP

New reimbursement models are re-inventing today's healthcare system. Questions that are commonplace in many other industries must start being asked of healthcare providers. What value proposition does the organization bring? How does it generate superior outcomes? How can it demonstrate results both financially and clinically?

The BDO Center for Healthcare Excellence & Innovation is of the opinion that mandatory bundled payment initiatives will continue to be forthcoming from both CMS and private insurers. Given this, BDO estimates that bundled payments, accountable care organizations, Medicare Advantage and other value-based purchasing payment initiatives will create $10 trillion in value for those who can adapt, and will result in $4 trillion in losses for those who can't. Investors on the winning end will have a thorough understanding of how reimbursement changes like bundled payments will impact pricing strategies, budget forecasting, business valuations and the potential for fraud.

For further information on this groundbreaking program and related value-based purchasing models, please visit the BDO Knows Healthcare blog and the CMS website on the CJR.

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THE OVERLOOKED ELEMENT OF VALUE IN DRUG PRICING STRATEGY

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

The drug pricing media hype has opened a new window into the many factors behind current pricing strategy, including competition, the cost of research and development, and the bottom line. But one key factor has not received the attention it merits: value. As healthcare reimbursements trend toward value-based payments, value is one piece of the puzzle that could make or break drug companies and will surely alter the playing field for healthcare stakeholders – including providers.

HOW WILL DRUG PRICING IMPACT HEALTHCARE PROVIDERS?

Hospitals are slowly but surely being asked to curate a cost-sensitive supply chain and function as a coordinator of suppliers. The recent move toward bundled payments (see previous article, "How Bundled Payments Will Redefine Value in Healthcare: A Primer for Investors") tasks hospitals with bringing together providers and vendors to ensure the aggregate costs of all of the services required throughout an episode of care—the surgery, the physician, the drugs, the appliances and equipment, and the care outside of the hospital—remain within the bundle price.

Pharmaceuticals play a big part of this picture—and their part will grow as highly drug-dependent oncology and cardiac bundles are developed. Pharmaceutical companies will need to identify their value proposition and price their products carefully according to value and outcomes to justify their place in the picture. Hospitals will have little reason to prescribe an expensive drug that doesn't work as often or as well as a competitor drug, and they may think twice about an ineffective drug that seems inexpensive but results in a higher readmission rate.

HOW CAN A HOSPITAL ASSESS A DRUG'S VALUE?

Value is determined by a variety of stakeholders—consumers, institutions that manage and produce care, drug manufacturers, and investors. And their points of view are constantly evolving: There's no scale that says what's best or what's value, which offers considerable opportunity for both drug developers and care providers to define and measure it.

One factor in determining a drug's overall value – and one that has not yet been broadly factored into a drug's price—is the "number needed to treat," or the number of patients who must receive a drug before it's deemed effective in a single patient. If the number needed to treat is 100, then one patient benefits from its use while 99 might receive and pay for treatment without the desired outcome—and they may suffer side effects. The potential risk of non-treatment may in some cases justify a high number to treat, but such factors have not been factored into a drug's price until now, when they are getting new attention with the rise of pay-for-performance.

To extend the concept further, hospitals should look at outcomes and how well a drug prevents the need for *future* care, not only in the short term, but *over a lifetime*. Take the recent discussion around hepatitis medications: While one drug is very expensive—up to $100,000—it is also considered a cure for a disease that could otherwise require millions of dollars in medical care over the course of the patient's lifetime. One could argue that the net present value for that investment is very significant. That's one component of value.

Of course, there's also the factor of convenience, just as we see in consumer products. If a patient uses the least expensive drug but must take it five times a day, that drug may not be very appealing to the healthcare provider that must administer

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DRUG PRICING STRATEGY

it. A somewhat more expensive drug that is administered once a day may ultimately have more value for the patient or the hospital. The tradeoffs depend on the hospital bringing the supply chain together and what it considers valuable. The largest providers, for example, may find that it's too expensive to deal with readmissions or litigation and unhappy patients—which means that even if the second-best drug is offered at a steep discount, that still may not be good enough to avoid being excluded.

HOW CAN A HOSPITAL LOOK BACK TO DETERMINE WHETHER VALUE WAS ACHIEVED?

A drug's value is difficult to forecast. To get a clear depiction of value, hospitals can look backward at readmission rates to assess how often a drug failed and whether it cost the provider more money to continue to treat the patient.

It's also important for hospitals to compare the claims about a drug's performance with the outcomes to verify that the predicted outcomes did in fact happen, especially as payment becomes explicitly linked to the clinical reported outcome. The need will increase for someone in organizations to verify that the clinical data is true and being accurately measured, and that the connections between drug, outcome and cost are being made.

Over the next 10 years, we believe that somewhere in the neighborhood of $10 trillion of value is going to be created in healthcare, and about $4 trillion is going to be destroyed. The pricing and reimbursement landscape is front and center in this changing landscape, so it's incumbent upon providers, suppliers and anyone with a financial interest in healthcare to understand these changes in order to adapt.

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HOW ARE CHANGING REIMBURSEMENT MODELS IMPACTING RISK?

7 Questions to Address This Quarter

By Venson Wallin, CPA, The BDO Center for Healthcare Excellence & Innovation

Healthcare providers are starting to feel the impact of the accelerating pace of reimbursement changes.

Delivery models are transforming, ushering in new opportunities and risks that organizations must manage. As providers navigate these rough waters, it's up to the organization's board and advisors to ensure the ship isn't taking on too much water. To do that, they should be asking the following questions to gauge how the organization is being impacted by reimbursement changes and how well prepared it is for a new environment.

1. What kind of financial impact is the shift to value-based reimbursement having on the organization?

The Centers for Medicare & Medicaid Services (CMS) is aggressively pushing alternative payment models; already, there are more than 38 different models in play. Commercial payers are increasingly moving in this direction, as well: UnitedHealthcare paid out roughly $43 billion in value-based payments to doctors and hospitals in 2015 and plans to increase such payments to $65 billion by 2018. In this environment, providers must uncover what models are working or not working and how these changes are impacting the organization's revenue. Fifty-one percent of hospitals said value-based payment programs have achieved positive ROI, but interoperability capabilities will continue to be a major concern over the next few years, according to the Healthcare Financial Management Association's (HFMA) Value-Based Payment Readiness Survey. Healthcare providers will need to consider what adjustments can be made to ensure the organization has the ability to share clinical information across the continuum and make positive results sustainable.

2. How is the organization planning to handle bundled payments?

CMS is moving to a mandatory bundled payment model for knee- and hip-replacements in April, affecting hospitals in 67 markets. The American Hospital Association (AHA) released an issue brief on Medicare's bundled payment initiatives in January, outlining the associated challenges for hospitals, as well as the opportunities to improve quality and achieve positive financial results. It's very likely that CMS will soon start mandatory bundled payments for other episodes of care—and other payers will soon follow. To achieve success under these initiatives, providers will need to invest in new capacity and infrastructure, and carve out new approaches for the future.

3. Does the organization have any new contractual commitments as a result of partnership and/or affiliation discussions, and how are they being vetted?

The move toward bundled payments and accountable care organizations (ACOs) is forcing increased collaboration between providers all along the care continuum, and giving rise to new contracts. Therefore, providers will need to consider what kind of settlement agreements are in those contracts and how the timing of those settlements will impact financial results.

4. How is the organization handling revenue decreases stemming from CMS reimbursement reductions?

There are a variety of programs creating potential reimbursement reduction issues. Among them is CMS' Hospital Readmissions Reduction Program—only 799 of the 3,400 hospitals in the program performed well enough to avoid a penalty for fiscal year 2016, and 38 will face the maximum 3 percent penalty. Many hospitals are facing penalties under the Hospital-Acquired Conditions Reduction Program, as well—758 of the 3,308 hospitals will face a 1 percent

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CHANGING REIMBURSEMENT MODELS

reduction in Medicare payments. Recently, 55 hospitals filed a lawsuit against the U.S. Department of Health and Human Services (HHS) because of Medicare payment reductions tied to a new CMS rule that classifies hospital stays of less than two midnights to be outpatient cases. As these programs are rolled out and enforced, hospitals and other providers must consider what efforts are being made to avoid penalties, and what kind of cost that presents in the short term versus long term.

5. What controls are in place to measure and validate the accuracy of quality outcomes?

There are hundreds of quality metrics that providers must track and report. CMS, commercial payers, healthcare providers and other parties have formed a Core Quality Measures Collaborative in an effort to reduce some of the complexities and increase multi-payer alignment around quality reporting, and issued a first set of core measures in mid-February. It's beneficial for organizations to stay abreast of these evolving rules and guidelines, in order to measure accurately, efficiently and in accordance with industry standards. In addition, some of the metrics hospitals use may incentivize providers to meet established measures in a manner that is not consistent with the organization's culture. It's critical that organizations have systems and processes in place to prevent fraud and compliance issues.

6. How do the organization's star ratings and quality metrics compare to peers'?

Medicare's Five-Star Rating system is becoming increasingly important as a measure of quality, with CMS announcing a major move to tie bundled payments to this rating system. These and other reimbursement changes are pushing hospitals to improve outcomes and reduce costs by creating networks of high-quality post-acute care partners. In turn, ratings and metrics will grow increasingly important in vetting and creating those partnerships. CMS is pushing forward with star ratings for hospitals, as well; last year, it introduced ratings based on patient experience. In April, CMS will publish a complementary rating, which will analyze a hospital's performance based on quality measures in seven key areas. As this develops, organizations will have to consider what kind of rating they can expect to receive and how that may affect long-term stability and viability.

7. What impact will the shift to quality reimbursement have on revenue recognition?

With bundled payments, ultimate settlements for allocation of payments among the network participants may occur much later than the period in which the services were provided. Organizations will need to consider the timing of recognition as well as the need for reserves for annual settlements.

Making the shift from volume to value will increase exposure to risk in new ways. These are the boardroom conversations that help minimize risk exposure as forward-thinking leaders and advisors guide their organizations through healthcare transformation.

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DID YOU KNOW...

Only 23 states increased their mental health budgets in 2015, according to an annual survey by the National Alliance on Mental Illness.

During the fourth quarter of 2015, the occupancy rate of skilled nursing facilities fell 0.1 percent, which brought the overall occupancy rate to 87.4 percent, according to a report by National Investment Center for Seniors Housing & Care.

Humana expects to lose between 200,000 and 300,000 individual members by the end of 2016, according to a report by the United States Securities and Exchange Commission.

UnitedHealthcare lost $720 million on its Affordable Care Act-compliant plans in 2015, according to its fourth-quarter earnings report.

Seven in 10 individuals with unaffordable, out-of-network medical bills did not know the healthcare provider was not in their plan's network, according to a survey by Kaiser Family Foundation.

The number of emergency room drug shortages sharply increased by 435 percent, from 23 to 123, between January 2008 and March 2014, according to a study by the Society for Academic Emergency Medicine.

A survey of more than 500 U.S. consumers planning to enroll in a 2016 health plan showed that 60 percent are unsure or do not have all their health data stored in electronic health records.

Between 2006 and 2014, the number of trials paid for by industry rose 43 percent and those paid for by the National Institutes of Health dropped 24 percent, according to a report in JAMA.

In 2015, there was a total of 200 telemedicine bills introduced in 42 states, according to a report from the National Conference of State Legislatures.

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March 23-25
2016 VA-DC HFMA Spring Education Conference*
The Westin Richmond
Richmond, Va.

March 24
Behavioral Health Lunch & Learn*
Maggiano's Little Italy
Costa Mesa, Calif.

March 24
TMA Healthcare Restructuring Presentation*
Deloitte CRG Offices
Dallas

April 7-9
American Bar Association 2016 Business Law Section Spring Meeting*
Fairmont Queen Elizabeth, Montreal and Hotel Bonaventure Montreal
Montreal, Canada

April 10-13
The 13th Annual World Health Care Congress & Exhibition
The Marriott Wardman Park Hotel
Washington, D.C.

April 13-15
The Beryl Institute Patient Experience Conference 2016
Sheraton Dallas Hotel
Dallas

April 14-17
American Bankruptcy Institute Annual Spring Meeting
JW Marriott
Washington, D.C.

April 27
Behavioral Healthcare Lunch and Learn*
Phoenix

April 27-28
Private Healthcare Investor New York Forum*
The Westin New York at Times Square
New York

May 4-6
AMIA iHealth 2016 Clinical Informatics Conference
Hyatt Regency Minneapolis
Minneapolis

May 24
Behavioral Healthcare Lunch and Learn
Nashville, Tenn.

May 25-26
Healthcare Dealmakers Conference*
The Adolphus Hotel
Dallas

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