Economic Outlook – The ‘Health’ of Healthcare

Central PA HFMA Chapter

January 2023

mazars

Contents

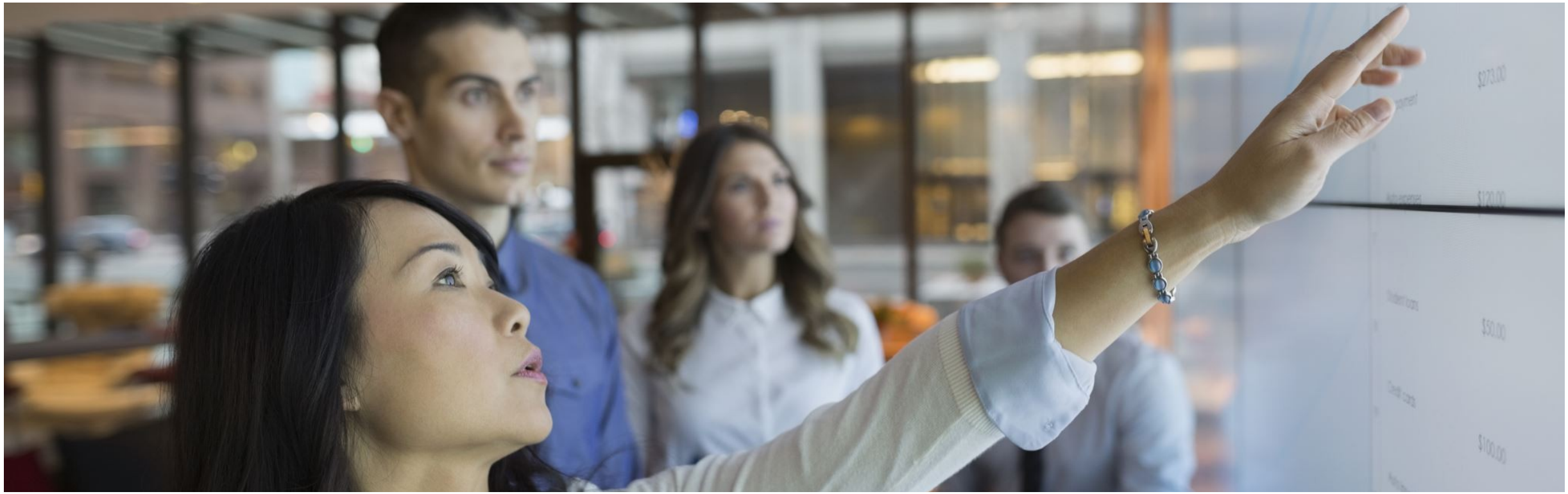
01

Section 01:

Current Trends

- The Harsh Truth

Industry experts say a financial turnaround is unlikely in the immediate future (and beyond)



Major Contributing Factors

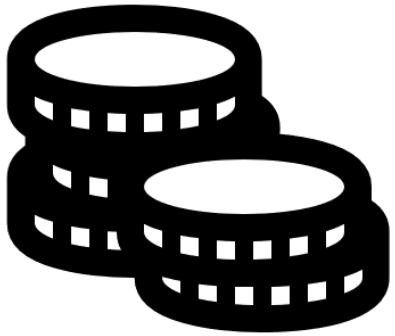
Through August of 2022, year-to-date operating margins remained in the negative at -0.3%

Labor

- Labor crunches and the need for costly travel nurses

Reimbursement

- Payment rates not covering hospital costs to perform procedures



Patient Volume

- Decreased elective procedures due to household budgets

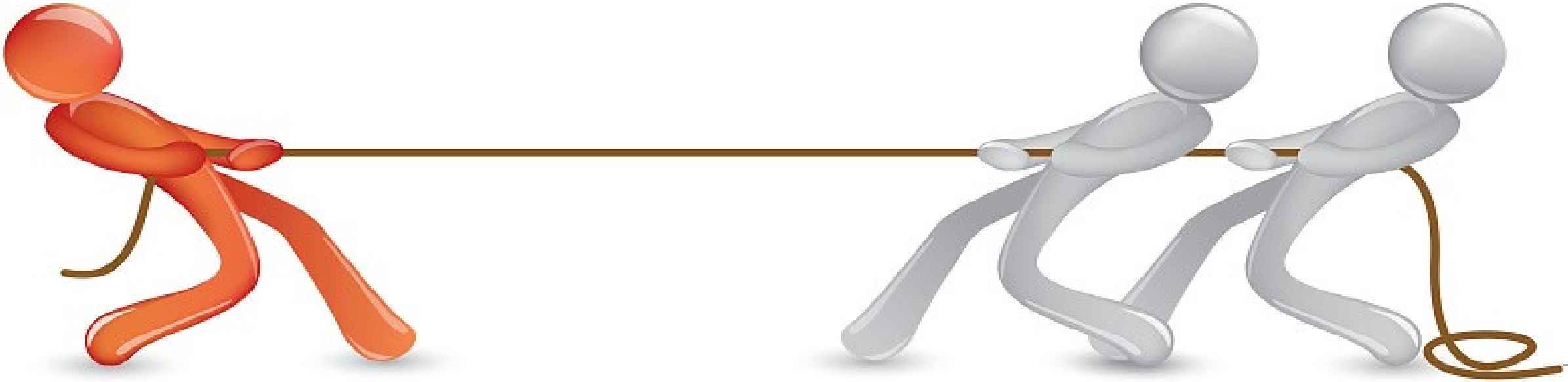
Labor Tug of War

Job openings fall in 2022 Q4

Employee quit rates are elevated

Wages have increased

Contract labor increases



Patient Volume & Physician Labor

Market dynamics of the healthcare landscape

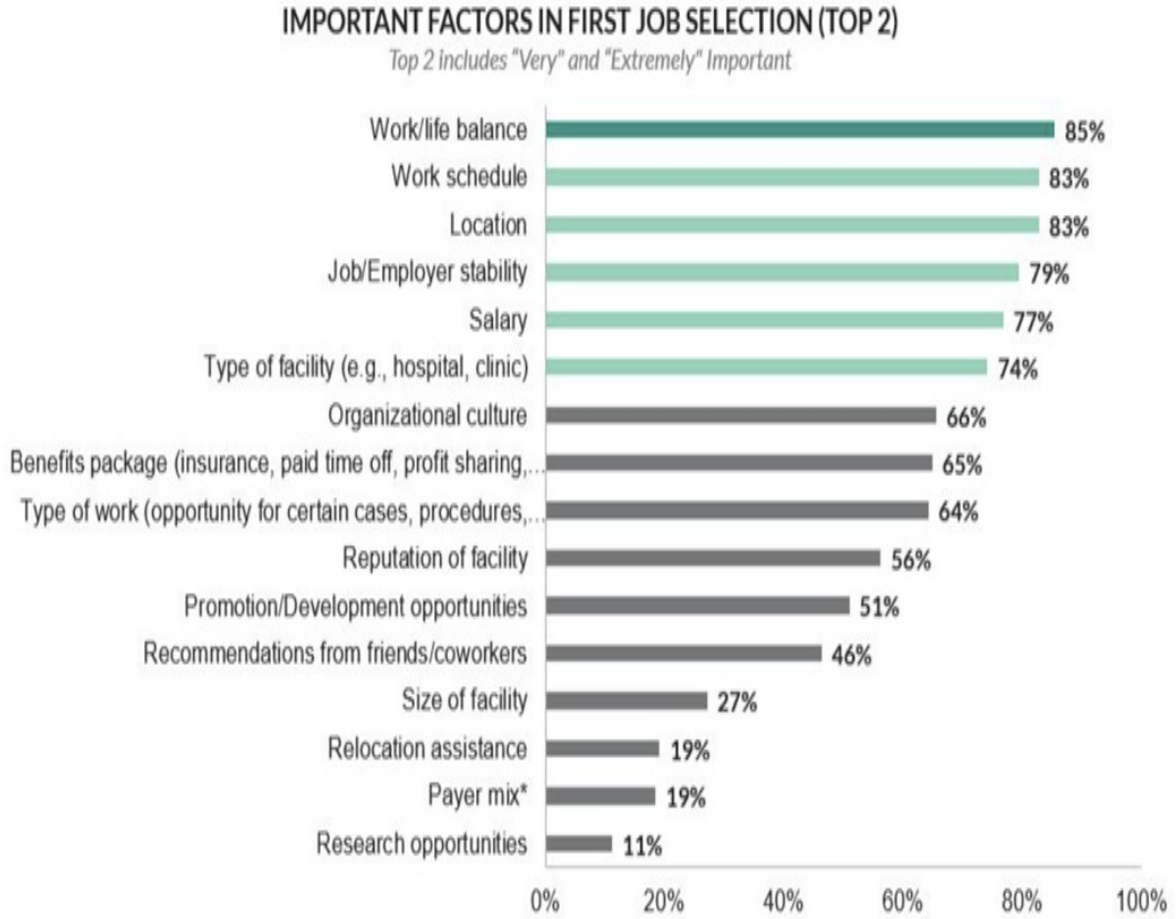
Physician Labor

Physicians working directly for hospitals has increased from 29% to 40% since 2012

Volume, productivity and referrals have not kept pace with contracts

Revenue

Changing Expectations = Retention Challenges



Forbes Predictions 2023

More and More Customer Segmentation

Should all patients receive the same clinical model?

Toxic Positivity Around Value-Based Care Will Abate

Does “value-based” care lower costs and create better outcomes for society?

Biopharmaceutical Innovation Will Continue to Impress

Will prices subside?_

Tech and Retail Will Continue to Inch Into Healthcare Delivery

Are you prepared?

COVID’s Impact Continues

How will volumes impact staffing ratios?

Progress on Clinician Burnout

Have you looked at the underlying causes for burnout?

Medicare Advantage Will Remain Under A Microscope

What % account for your patient population?

Home-Based Care Will Get A Closer Look

Is the home the best place for care?

02

Section 02:

Government Implications

Midterm Election Results

HEALTH POLICIES & TOPICS THAT CAN SEE ACTION IN 2023

Bipartisan Supported programs that are set to expire in 2023 and therefore will require congressional intervention to be sustained

- **Medicaid disproportionate share hospital (DSH): expires October 1, 2023**
- **Community health center funding expires October 1, 2023**

Republicans are likely to scrutinize

- **Medicare**: All aspects of the program / focus on solvency.
- **Hospitals**: Industry consolidation, non-profit status, site-neutral payment policy and the 340B drug discount policy.
- **Physician/Practitioner**: Perennial problems with formula-driven updates more commonly known as MACRA.
- **Medicare drug space**: Targeted legislation to repeal specific provisions of Democrat Legislation
- **End of the COVID-19 Public Health Emergency: Medicaid Unwinding & PHE Flexibilities.**

• Healthcare Federal Regulation

What Providers Can Expect

No major legislation about healthcare is likely to pass congress in 2023

Federal Level Actions - 2023

- Federal Trade Commission will increase scrutiny of hospital consolidation
  - FTC will intensify its enforcement of privacy & security compliance
- **HHS will provide hospitals with concessions for maintaining 340B drug program discount**
- HHS will incorporate specific goals & measures of diversity, equity & inclusion
- Center for Medicare & Medicaid Innovation will modify alternative payment models that will require participants to accept downside risk
- **Monitor provider compliance with the core-data anti-blocking interoperability for electronic health information**
- **Congress will extend the temporary 3% payment boost through 2023**

03

Section 03:

Rural Hospitals in Crisis

REH – Rural Emergency Hospitals
Final Regulations

New legislation seeks to preserve healthcare in areas with high risk of hospital closure

Background

- 175 rural hospitals have closed since 2005
- Around 600 more could close within the next year
  - This accounts for 30% of all rural hospitals

New Structure

- Critical Access Hospitals and Rural Hospitals with fewer than 50 beds can convert to REHs
- Reimbursement will be provided for emergency and observation care
  - Must cease in delivering inpatient care
  - Not eligible for 340b program

- REH – Rural Emergency Hospitals

Payment & Policy

Must deliver emergency and observation care and can choose to deliver other services under the Medicare payment system

Payment

- Reimbursement will be 105% of outpatient rate
- Facilities will receive a monthly fee of ~$273k starting in 2023
  - Will increase annually

Policy

- Must have a clinician on-call that can arrive within 30 minutes
- 24/7 ED staffing
- Maintain a quality assurance program
- Implement programs for infection prevention

Alternative Options

Micro Hospital

- 24/7 care that includes inpatient and low complexity surgical options
- Not limited in # of beds (typically 8-10 IP beds),
- Not limited to 96hours
- Can be in Rural or Urban settings
- Work better by having closer proximity to a larger hospital that can provide the support network for supplies, (cannot be too rural)
- A focused service to ensure volumes
- Fully licensed – specialty, primary care, rehab services, wide range of surgical procedures

Critical Access Hospital

- 24/7 Inpatient and Surgical Options
- Capped at 25 acute inpatient beds,
- Must be more than 35 miles from another hospital
- Reimbursed at a higher rate but lose financial efficiency due to distance from support network.
- Critical access average length of stay is limited to 96 hours or less
- Services closer to full spectrum like labor and deliver, surgical as well as scope of services diagnostic/ lab services

Free Standing ER

- 24/7 Emergency care only
- No Inpatient beds
- imaging, laboratory capabilities.
- Do not offer primary care / specialty care services
- Surgical care limited to ER MD capabilities but bottleneck patient care
- Avoid Observation due to limited space and care coordination support services

05

Section 05:

Mazars Recommendations

Mazars Recommendations

OP Market Growth (59% CEOs)

Re-engage patients

Create Access

Focus Patient Convenience Access Points

Workforce Optimization (52% CEOs)

Develop Automation Capabilities

Fully Enable Patient Self Service

Extend Services & Teams

Payment Performance

Fight Denials Move to Proactive Model

Reduce Self-Pay Effort to Collect

Monitor 2023 E&M

Cost Containment (41% CEOs)

Reduce Overhead

Review Supply Pricing / Performance

Improve Care Management

06

Section 06:

Case Study

Case Study

Client- Northeast US Health System

The Problem

- A large health system in the northeast covering 2 states approached Mazars in late 2022 to understand the economic outlook in 2023, better understand current operations from a neutral perspective and prepare a strategic plan to set them up for success financially

Case Study

Identified Opportunities by Focus Area

Corporate Spend

- Central vs Decentral Review
  - Direct and Shadow Overhead
  - Duplication of Roles

Medical Group Operations

- Team Based Care
- Scheduling Optimization
- Evaluate Automation Potential

Care Management

- Overlap & Missing Roles
- ED / Hospitalist Effectiveness
- Length of Stay Opportunities

Post Acute Care

- Quality, Financial Review
- Geographic/ Regionalization Approach

Revenue Cycle

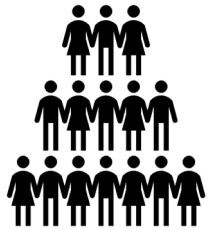
- Structure
- Denial Management
- Scheduling

Payer Behavior

- Reimbursement Rates
- Denials

Service Line Review

- Essential / Core Services
- Provider Workforce Risk
- Margin Performance



Executive Summary

Financial Impact by Area of Focus

Assessment Category	Operational Financial Impact (Low / Medium / High)
Corporate & System Overhead	$14.8M (Year 1)
Integrated Medical Group	$14.4M / $21.5M / $24.8M
Revenue Cycle	$18.9M
Post-Acute Care[1]	$12M
Case Management & Care Coordination	$13M / $23.8M / $34.5M
Service Line[2]	$14M / $17M / $20M
Assessment Total	**$87.1M / $108M / $125M**
CDM Order Entry Reconciliation Review[3]	$227K / $1.1M / $2.3M
Assessment Total (w/CDM Recon)	**$87.3M / $109.1M / $127.3M**

Questions

Speakers

C.J. Ehrentraut, MBA, MPS, CRCR
Manager
Healthcare Transformation

C.J. has over fourteen years of progressive Revenue Cycle experience in provider and consulting settings with a comprehensive background in Patient Access and Billing. He is well-versed in various solutions and adapts to new technology quickly. C.J. has managed Patient Access and Billing operations for both hospital and multi-site physician clinics with a focus on design and implementation of various operating models to increase collections, streamline workflows to facilitate the reduction of AR and denials, as well as creating policies to increase patient satisfaction. He utilizes strong organizational and management skills to solve problems, improve processes and drive results.

David Turner, MSA
Director
Healthcare Transformation

David has over twenty-five years of progressive healthcare industry experience with ten of those years in executive leadership roles both in hospital and medical group operations. As a former Vice President of Medial Group Operations, his blend of experience both from a finance and operations background brings a financial operations perspective to solutions and projects. David also has extensive experience with provider compensation plan designs, optimizing provider performance, new service evaluation and implementation, practice onboarding, ambulatory clinic space planning and design, population health alignment with operations, as well as developing financial accountability via effective KPI reporting and business analytics.

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