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2020 Advisory Conference
October 27–29
Converging knowledge and behaviors to deepen client relationships
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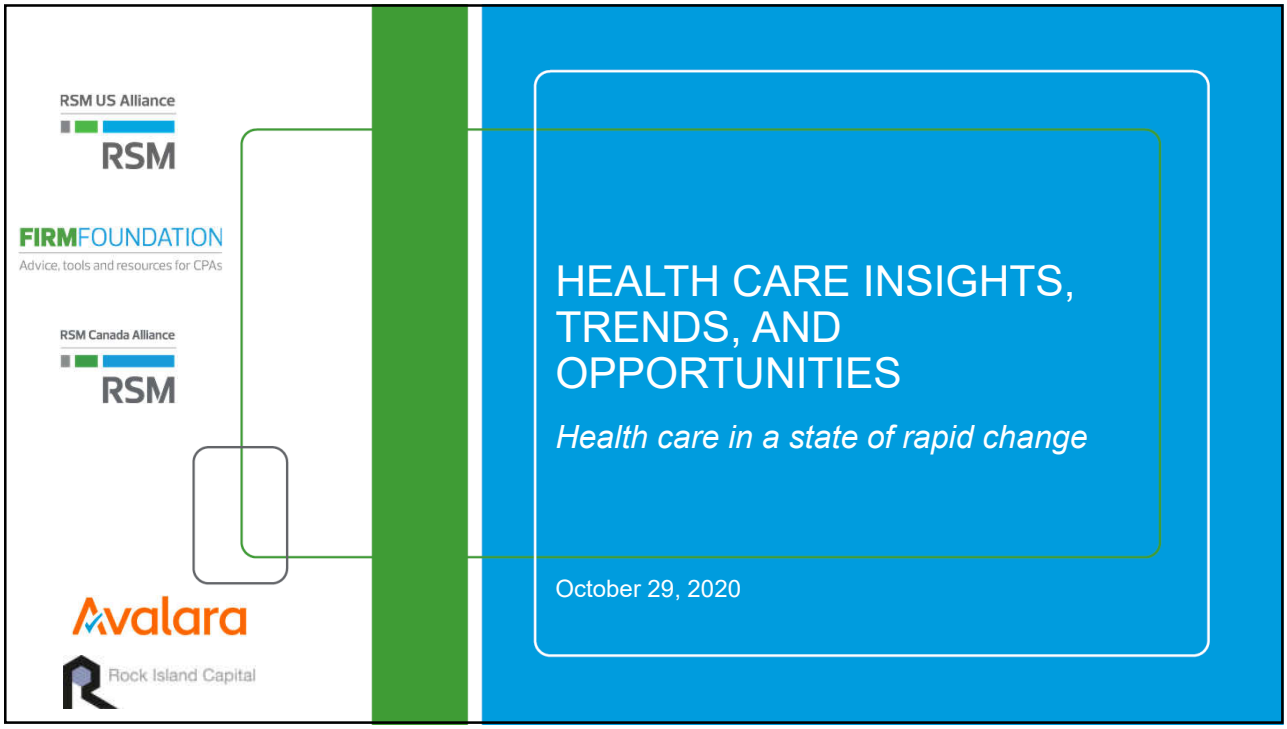
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HEALTH CARE INSIGHTS, TRENDS, AND OPPORTUNITIES
Health care in a state of rapid change
October 29, 2020

Speaker

Jessika Garis

Senior Health Care Industry Analyst and Director

- 11+ years of experience serving companies throughout the health care ecosystem
- RSM's Health Care Internal Audit and Compliance Leader
- Fellow within RSM's Industry Eminence Program

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Speaker

Jim Sink

Health Care Principal – Health System Sector Lead

- 30 years of experience providing consulting services to health care providers and payors
- Multidisciplinary focus
- Leads a national team focused on health systems

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Agenda

Topic	Field of study	Minutes
Health Care Today (COVID Response)	Specialized knowledge	15
Health Care the Day after Today (Price Transparency)	Specialized knowledge	20
Health Care Tomorrow (Digital transformation)	Specialized knowledge	15
Discussion	Specialized knowledge	10

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Objectives

By the end of this course, you will be able to:

- Describe what health care companies can think about as it relates to their ***COVID Response***
- Understand what ***Price Transparency*** means for the ecosystem
- Explain ***Digital transformation*** effects to the ecosystem

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HEALTH CARE TODAY (COVID RESPONSE)

Jessika Garis

COVID-19 Reaction – Health Care

1. UNCERTAINTY

- Are you familiar with our Coronavirus Resource Center?
- Would you like to have a discussion with one of our senior industry analysts?
- Each provider is different; what concerns do you have around maintaining the volume and quality of care you provide?

2. GUIDANCE & REGULATION

- How are you dealing with expanded coverage and changing reimbursement related to the pandemic?
- Are you taking advantage of expanded virtual health access? How might this change your long-term virtual health strategy?
- Are you familiar with the provisions of the CARES act that impact your company?

3. SUPPLY & DEMAND SHOCK

- How long can you sustain a period of few or no elective or schedulable procedures?
- Have you seen an increase in PPE or other supply cost? How soon would you notice an increase with your current reporting?
- How many days of PPE do you have on hand?
- Do you have concerns about any critical vendor's solvency?

4. WORKFORCE DYNAMIC

- How should I be communicating and managing employees, both onsite and virtual?
- How do I administer new Federal and State Leave Regulations?
- How are you supporting your clinicians as you ask them to do more?
- Are you concerned with turnover, including physicians paid on productivity?

5. LIQUIDITY

- How long can your balance sheet last in this environment before you need additional financing?
- Have you discussed with extending credit or otherwise getting relief on debt?
- Are you familiar with government loan programs, how to access and terms?

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CARES Act

$100 billion + $75 billion

$45 billion

$200 million

Public Health and Social Services Emergency Fund	Medicare Reimbursement	Federal Emergency Management Agency	Federal Communication Commission
• Fund: $175 billion • Broad definition of health care provider • Costs • Lost revenue	• 20% bump • Temporary suspension of sequestration • Telehealth • DSH payment cuts delayed • Advanced payments from Medicare	• Fund: $45 billion • Governmental hospitals • Nonprofit hospitals • State-specific • No reimbursement for lost revenue	• Fund: $200 million • Governmental hospitals • Nonprofit hospitals

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Timeline and changes for Provider Relief Funds

CARES Act Issued
In March of 2020 the President signed the CARES Act into law

June Definition of Lost Revenue
Focused on:
- Revenues
- Budget to actual or CY to PY

September 19th Reporting Guidance
Introduced:
- Two step process
- Indication of Step 1 (cost identification) first then Step 2 (lost revenues) in process
- ~~Redefines lost revenue to really lost margin on a calendar year over year basis~~

October 22nd Post Payment Notice of Reporting Requirements
HHS reverts lost revenue definition to, "negative year over year change in net operating income."

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Experts from reporting guidance

2. PRF payment amounts not fully expended on healthcare related expenses attributable to coronavirus are then applied to patient care lost revenues, net of the healthcare related expenses attributable to coronavirus calculated under step 1. Recipients may apply PRF payments toward lost revenue, up to the amount of the difference between their 2019 and 2020 actual patient care revenue.

Does this mean I have to do Step 1 then Step 2, or can I skip Step 1?

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Experts from reporting guidance

2. Expenses Attributable to Coronavirus Not Reimbursed by Other Sources (2020 only)

Expenses attributable to coronavirus may be incurred both in treating confirmed or suspected cases of coronavirus, preparing for possible or actual coronavirus cases, maintaining healthcare delivery capacity, etc.

How broadly should this be interpreted?

In this section, Reporting Entities that received **between $10,000 and $499,999 in aggregated PRF payments** are required to report healthcare related expenses attributable to coronavirus, net of other reimbursed sources (e.g., payments received from insurance and/or patients, and amounts received from federal, state or local governments, etc.) in two aggregated categories: (1) G&A expenses and (2) other healthcare related expenses. These are the actual expenses incurred over and above what has been reimbursed by other sources.

Recipients who received **$500,000 or more in PRF payments** are required to report healthcare related expenses attributable to coronavirus, net of other reimbursed sources, and they must do so by reporting more detailed information within the two categories of G&A expenses and other healthcare related expenses, according to the following sub-categories of expenses:

Does this include IGT/UPL type payments? Does it include out of period settlements?

3. Lost Revenues Attributable to Coronavirus

In this section Reporting Entities provide information used to calculate lost revenues attributable to coronavirus, represented as a negative change in year-over-year actual revenue from patient care related sources. Revenues and expenses in this section include all lost patient care revenues and patient care cost/expense impacts.

What if there are other reasons my revenue changed YOY?

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FEMA process

Submit a Request for Public Assistance to State EMA → Login/ Create Account – PA Portal → Attend Virtual Application Briefing → Submit COVID-19 PW (and docs) → FEMA and State Review Docs → Sign Final Grant → Receive Funding

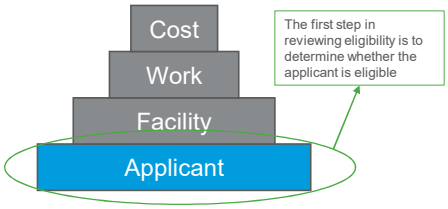
Private Nonprofit Organizations

- A current ruling letter from the U.S. Internal Revenue Service granting tax exemption under Sections 501(c), (d) or (e) of the Internal Revenue Code of 1954
- Documentation from the state substantiating it is a non-revenue producing, nonprofit entity organized or doing business under state law
- Examples may include:
  - Universities
  - Hospitals
  - Ports
  - Utilities
  - Hospices
  - Clinics
  - Nursing homes
- Facilities established or primarily used for political, athletic, recreational, vocational or academic training, conferences or similar activities are **not eligible**

State and Local Governments

State and local governments are considered eligible applicants. State and local governments include:

- The District of Columbia
- American Samoa
- The Commonwealth of the Northern Mariana Islands
- Guam
- Puerto Rico
- The U.S. Virgin Islands



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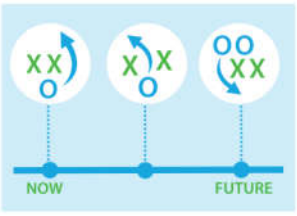
HEALTH CARE THE DAY AFTER TODAY (PRICE TRANSPARENCY)

Jim Sink

Transparency readiness

Transparency Strategy



- Develop transparency strategy, governance, roadmap and timeline
- Meet regulatory requirements by January 1, 2021
- Rationalize your CDM(s), and consumer friendly 300 list
- Align revenue cycle with transparency objectives
- Benchmark, assess, simplify, and standardize payer contracts
- Embrace risk, value-based, prospective and capitated, while de-emphasizing charge-sensitive payment arrangements
- Address unjustifiable clinical/cost variation
- Leverage data analytics, patient-level costing, and clinical reporting

Reporting Requirements

- Share CDM in machine readable format
- Disclose five identified standard charges including negotiated payments for all payers separately for all items, services and service packages (including commonly bundled items)
- Share standard charges of all hospital and professional items and services in a consumer-friendly format for 300 shoppable procedures
- Consider online estimation tool

CDM Rationalization

- Build net revenue model
- Review managed care contracts
- Evaluate existing procedure, service type, and location variabilities
- Understand your cost, develop cost based algorithm
- Level cost-based market position
- Propose enterprise-wide rational pricing methodology
- Align your chargemaster(s)

Revenue Cycle Alignment

- Develop digital patient relationship improvement strategies
- Embrace automation
- Select/implement patient liability estimation tools
- Optimize scheduling processes
- Evaluate authorization and benefits workflow
- Enhance payment flexibility at the point of estimation

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How did we get here?

Expenditures

U.S. health care expenditures and rates of inflation continue to lead the world and dominate federal expenditures.

Consumerism

Young consumers are less loyal, leverage data, information and technology to spend more thoughtfully, while seeking greater value than older generations.

Media exposure

Media expose irrational pricing strategies and organizations not fully prepared for transparency.

Regulatory Compliance

Providers and payers are required to disclose standard charges, negotiated rates and cash prices for all items and services on their website, enabling a more level competitive environment, and determination of consumer value.

Digital Transformation

Technology, analytics and automation enable an enhanced digital patient relationship, impacting ultimate value equation, reduced clinical / cost variation, spend determinations and overall patient experience.

Value Based Economics

Will provide opportunity to those prepared to compete on value as free market forces are restored.

Realignment

Health care trade organizations encourage realignment of charges, price and cost data. Comparative clinical outcome information is needed to support informed consumer health care spend decisions and to restore free market forces and economic accountability among health care providers.

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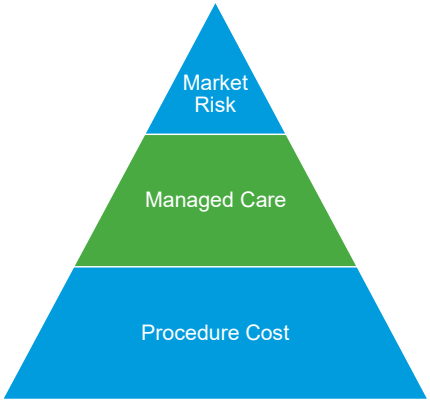
CDM Rationalization



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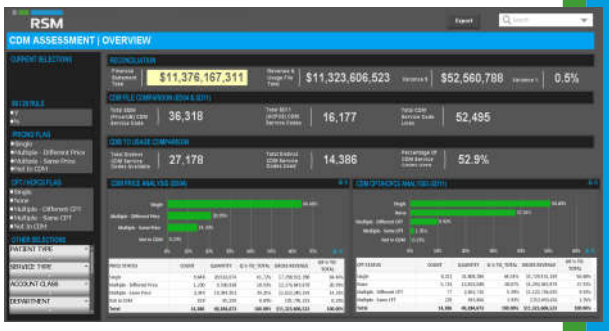
Transparency Risk

- Which services drive revenue?
- Which charging strategies drive revenue?
  - Room and bed
  - Acuity based
  - Supplies
  - Pharmaceuticals
- Which services are most visible?
  - Imaging
  - Elective surgeries
  - Therapies
  - Women's services
- Which services are, or should be, bundled?
- Identify redundancy, unused, and inactive line items



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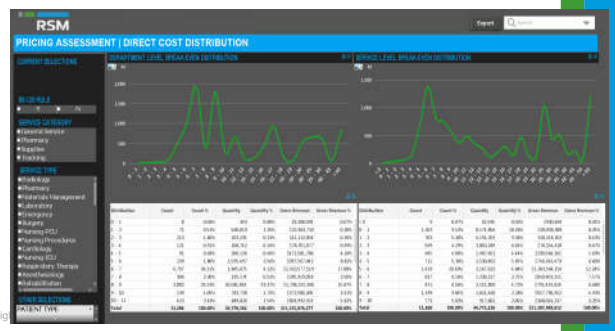
Procedure Cost Considerations

- What is the availability / precision of cost accounting?
- In the absence of reliable cost accounting, leverage cost surrogates. (e.g. APC, PFS, CLFS, etc.)
- Define current/future state relationship between cost, cost surrogate, and price.
- Develop cost-formulary pricing methodology leveraging either cost or cost surrogate data and departmental BE (breakeven) point.
- Define cost corridor (e.g., mark-up floor, ceiling) to soften implementation of cost-based methodology. (Cost corridors can be narrowed over time as market begins to follow cost-based pricing corrections.)
- Align service line mark-up levels with defined corridors, market, and net revenue requirements.



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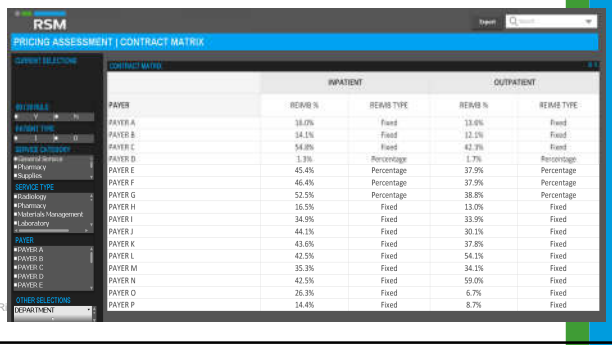
Managed Care Considerations

- Which payers drive revenue?
- What are net revenue incentives?
  - Charge based
  - Value-based
  - Prospective Rates (DRG, APC, Fee schedules)
  - Per diems, case rates
- Do agreements include “lower of charges” provisions?
- Do agreements include punitive charge limitations?
- Do agreements include outlier, stop loss provisions, or other claim level payment algorithms?
- Do agreements include carve-out provisions.
- Compare actual versus expected payment percentages by completing a ZBA analysis to test modeling assumptions, and to identify potential payer leakages.



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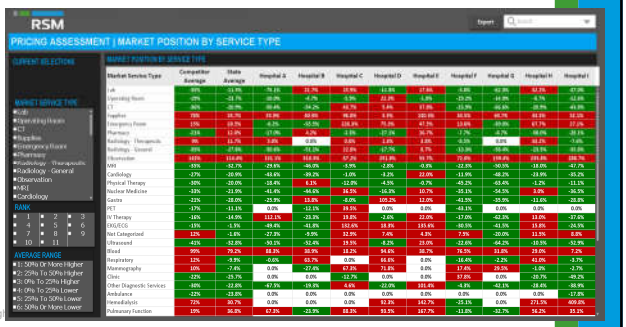
Market Considerations

- Does market matter?
- Understand market positioning locally, regionally, and nationally
- How should market factor into a rational strategy?
- Can a strategy be rational and align with market?
- When should you lead the market?
- When should you follow the market?



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HEALTH CARE TOMORROW (DIGITAL TRANSFORMATION)

Jessika Garis

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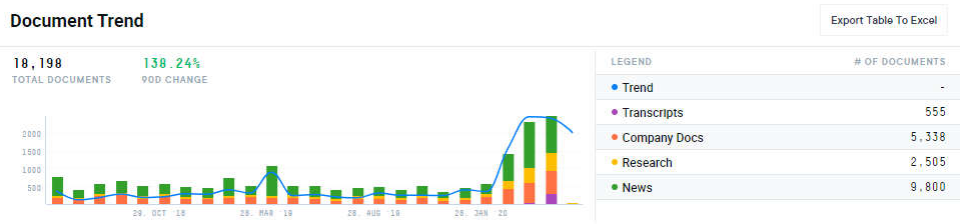
Telemedicine

- Telemedicine
  - Adoption – seeing between 30-100%+ increase
  - Methods – video, phone, chat, chat bot, remote monitoring
  - Reimbursement – Medicare made temporary changes, commercial payors are varied

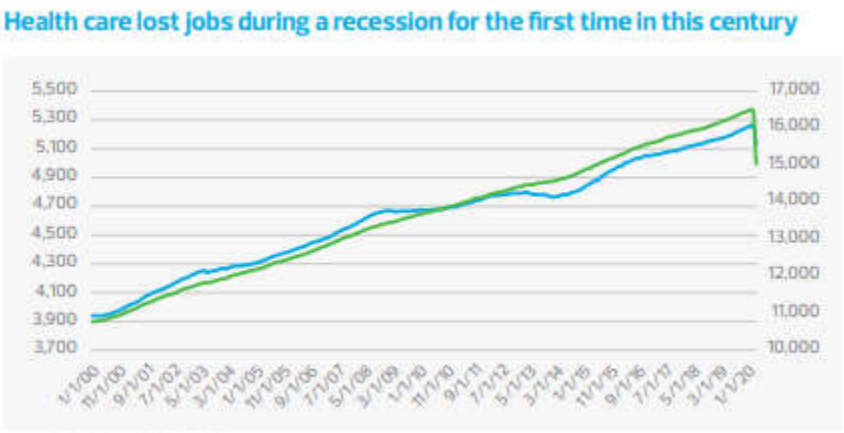


Telemedicine

- Telemedicine
  - Specialties – ophthalmology, optometry, endocrinology, dermatology, others
  - Growth – Piper Sandler

- **COVID-19 doubles the Virtual Care TAM to >$150B.** We estimate that the U.S. Telemedicine market grew from $20B pre-COVID to $95B post, consisting of a $32B lift in Medicare, $17B lift in Commercial, $14B in Medicaid and a $4B lift in OOP. Because reimbursement is now available for acute episodes as well as chronic conditions, we believe the Remote Patient Monitoring market grew from $55B pre-COVID to $59B post, resulting in a total virtual care addressable market of $154B.

Health care employment?



Source: Bloomberg LP; RSM US LLP

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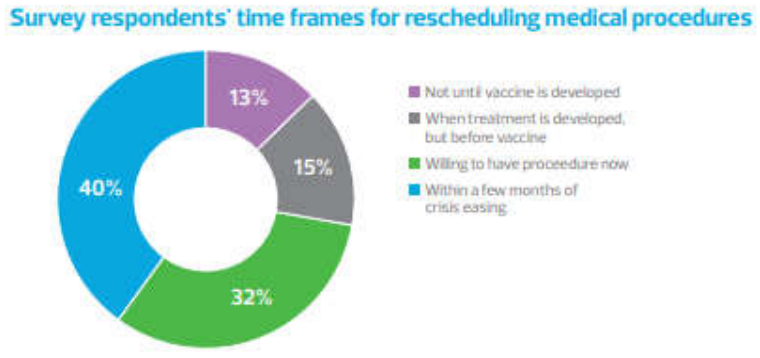
When are electives coming back?



Source: JP Morgan; Bloomberg

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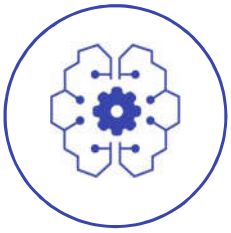
Automation spectrum

Basic Automation
Behaves like a person

- Clear (yes/no) business rules
- Structured data
- Workflow automation
- Attended or unattended execution
- Primary user interface based

Intelligent Automation
Learns like a person



- Decisions driven by data rather than code (learning capabilities)
- Extends basic automation capabilities
- Unstructured data extraction
- Natural Language Processing (NLP)

Cognitive Automation
Thinks like a person

- Self-learning & self-optimizing
- Image recognition (computer vision)
- Large data set processing
- Pattern identification & predictive analytics

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