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What are the implications of the new tax law to business owners?

HEALTHCARE INSIGHTS

The Due Diligence Imperative: The Healthcare Reimbursement Environment

(Part Two of a Six-Part Series)

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The first part of this six-part series set forth an overview of the due diligence imperative for valuation professionals, in the context of the *Four Pillars of Healthcare Value,* i.e., Reimbursement, Regulatory, Technology, and Competition. In part one of this series, the authors also provided a definition of due diligence and the two classes of information generally required for due diligence related to a healthcare valuation engagement. To sum up, due diligence may be generally defined as:

(1) "such a measure of prudence, activity, or assiduity, as is properly to be expected from, and ordinarily exercised by, a reasonable and prudent man under the particular circumstances; not measured by any absolute standard, but depending on the relative facts of the special case"; and,

(2) "an investigation in order to support the purchase price of the business."[1]

The two classes of information generally required for due diligence related to a healthcare valuation engagement are as follows:

(1) General research—Research that is not specifically related to, or obtained from, the subject enterprise, asset, or service being appraised; and,

(2) Specific research—Information specific to the subject enterprise, asset, or service, that is typically obtained from the client or the appropriate contact designated by the client.[2]

This second installment will review the due diligence process as it relates to healthcare reimbursement.

HEALTHCARE REIMBURSEMENT

Healthcare reimbursement may be defined as the payment received by providers for the services that they render to patients, most of which reimbursement is received from third party payors, e.g., public (government) and private (commercial) payors.[3] The U.S. government is the largest payor of medical costs, primarily through the Medicare and Medicaid programs; this significant market share allows the U.S. government to exert a strong influence on the healthcare reimbursement environment.[4] In 2015, Medicare and Medicaid accounted for an estimated $646.2 billion and $545.1 billion in healthcare spending, respectively, combining for approximately thirty-seven percent

1 For more information, see the first installment of this six-part series: "The Due Diligence Imperative for the Valuation of Healthcare Enterprises, Assets, and Services" *The Value Examiner*, NACVA (November/December 2017).

2 *Ibid.*

3 "*Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services*" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, Volume 1, Hoboken, NJ: John Wiley & Sons, Inc., 2014, p. 85.

4 "How the Government as a Payer Shapes the Health Care Marketplace" By Tevi D. Troy, *American Health Policy Institute* (AHPI), December 1, 2015, http://www.americanhealthpolicy.org/Content/documents/resources/Government_as_Payer_12012015.pdf (Accessed 8/14/2017), p. 1.

of all healthcare expenditures.[5] The prevalence of these public payors in the healthcare marketplace often results in their acting as a price setter, i.e., being used as a benchmark for private reimbursement rates.[6] The healthcare reimbursement environment is currently undergoing a paradigm shift, from reimbursement based on the volume of services provided, to reimbursement based on the value of services provided, which shift was recently manifested in the move away from the sustainable growth rate (SGR), and the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). This volatility requires the analyst to conduct a thorough and robust due diligence exercise, as the reimbursement trends of the past may not hold true in the future.

CONDUCTING GENERAL RESEARCH

In conducting the general research related to the subject interest being appraised, the analyst should first develop knowledge base related to the healthcare reimbursement environment, obtain the data required to benchmark the reimbursement at issue in the engagement, and, based on that, reach an adequate understanding of the pertinent reimbursement trends in the marketplace, all of which will allow the analyst to develop their observations, findings, conclusions, and opinion, and determine any necessary assumptions to be made regarding these future trends related to the subject property interest being appraised. One of the principal valuation techniques for which the general research is used is reimbursement benchmarking.

To compare the reimbursement being received by the subject interest, the analyst may utilize industry normative benchmark survey data, depending on the type of reimbursement involved. For example, reimbursement rates may differ depending on whether: (1) the payor is public or private; (2) the services being provided is in an inpatient or outpatient setting; and/or, (3) the reimbursement at issue relates to the professional or technical component (i.e., whether it is payment for the work of the provider, or for the use of a facility). Upon an assessment of these factors, the analyst can then determine the type of reimbursement benchmark survey data that is most appropriate.

Some of the information that the analyst may want to determine in order to facilitate the benchmarking analysis may include, but is not limited to:

(1) Medicare payments in the base year;
(2) Medicare reimbursement rates on a specific date (of the project);
(3) Projected Medicare reimbursement for the next three to five years;
(4) Medicaid to Medicare fee index; and,
(5) Commercial insurance reimbursement rates.

The various sources of information (some of which sources are free and some of which are available for purchase) that may contain this information may include, but are not limited to:

(1) American Hospital Directory, which "provides data and statistics about more than 7,000 hospitals nationwide…[and] includes both public and private sources such as Medicare claims data, hospital cost reports, and commercial licensors";[7]
(2) GuideStar, which aggregates nonprofit reports and Internal Revenue Services (IRS) Form 990s for over 1.8 million non-profit organizations;[8]
(3) Medicare Cost Reports,[9] which contain various data points for a facility, such as "facility characteristics, utilization data, [and] cost and charges by cost center";[10]
(4) Physician Compare,[11] published by CMS, which allows the public to compare providers enrolled in Medicare across numerous data points, including utilization and payment data;
(5) Provider compensation and productivity survey

5 "National Health Expenditure Projections 2016–2025—Tables" *Center for Medicare and Medicaid Services*, March 21, 2017, https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsprojected.html (Accessed 8/14/17), Table 3.

6 "*Medicare's Role in Determining Prices Throughout the Health Care System: Mercatus Working Paper*" By Roger Feldman et al., Mercatus Center, George Mason University, October 2015, http://mercatus.org/sites/default/files/Feldman-Medicare-Role-Prices-oct.pdf (Accessed 8/14/2017), p. 3–5.

7 American Hospital Directory, https://www.ahd.com/ (Accessed 10/26/17).

8 Note that, the majority of hospitals are tax-exempt organizations. GuideStar, http://www.guidestar.org/Home.aspx (Accessed 10/26/17).

9 Cost Report Data, https://www.costreportdata.com/index.php (Accessed 10/26/17).

10 "Cost Reports" *Centers for Medicare & Medicaid Services*, https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports/ (Accessed 10/26/17).

11 "Physician Compare" Medicare.gov, https://www.medicare.gov/physiciancompare/# (Accessed 10/26/17). Note that, the procedural codes reported are *Healthcare Common Procedure Coding System* (HCPCS). See, e.g., "Medicare Provider Utilization and Payment Data: Physician and Other Supplier PUF CY2015" data.cms.gov, https://data.cms.gov/Medicare-Physician-Supplier/Medicare-Provider-Utilization-and-Payment-Data-Phy/sk9b-znav (Accessed 10/26/17).

data from associations such as:
   (a) Medical Group Management Association (MGMA);[12] and,
   (b) American Medical Group Association (AMGA);[13]

(6) The relevant Medicare Fee Schedule from CMS;[14]
(7) The state's workers' compensation fee schedule(s);
(8) The state's Medicaid fee schedule(s);
(9) Definitive Healthcare, which reports financial and clinical metrics (including net patient revenue, operating income, and average payment per claim by provider) for hospitals and healthcare providers;[15]
(10) FAIR Health, which aggregates information on medical claims (by CPT code) from a significant number of commercial insurers across the U.S.;[16] and,
(11) The Henry J. Kaiser Family Foundation, which provides the Medicaid to Medicare fee index (note that, the data is stratified by state, and by primary care, obstetric care, or other).[17]

The information in 1–11 presents some of the data sources and means by which the analyst may perform the requisite analysis for comparing the subject reimbursement at issue to industry normative benchmarking data and provides the context by which the current reimbursement environment can be contrasted with historic trends, to facilitate the analyst's assumptions and calculations necessary to predict future reimbursement.

12 Provider compensation data from MGMA is provided through its online DataDive database. MGMA DataDive, Medical Group Management Association, https://www.mgma.com/industry-data/datadive-resources (Accessed 10/26/17).
13 "Benchmarking Surveys" *American Medical Group Association*, https://www.amga.org/wcm/PI/surveys_pi.aspx (Accessed 10/26/17).
14 "Fee Schedules—General Information" *Centers for Medicare & Medicaid Services*, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FeeScheduleGenInfo/index.html (Accessed 10/26/17).
15 "Financial & Clinical Metrics" *Definitive Healthcare*, https://www.definitivehc.com/financial-metrics (Accessed 10/27/17). Note that, Definitive Healthcare recently acquired Billian's HealthDATA, another type of healthcare information database. "Definitive Healthcare has acquired Billian's HealthDATA!" Definitive Healthcare, https://www.definitivehc.com/definitive-healthcare-has-acquired-billians-healthdata (Accessed 10/27/17).
16 FAIR Health, https://www.fairhealthconsumer.org/ (Accessed 10/27/17).
17 "Medicaid-to-Medicare Fee Index" *The Henry J. Kaiser Family Foundation*, http://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/ (Accessed 10/26/17).

SPECIFIC RESEARCH RESOURCES

Specific research is typically collected from the Subject Entity, and specifically from the client, or the appropriate contact designated by the client, e.g., chief information officer (CIO), chief financial officer (CFO), or legal counsel, when pertinent. As the requested documents and information are gathered, an engagement-specific database may be useful to appropriately account for the data in a manner that adequately identifies, classifies, and stores it, so that it may be timely and efficiently retrieved for use (ICSR).

The reimbursement data requested of, and obtained from, the Subject Entity should include both the charges and collections, as well as the amount received by the Subject Entity (i.e., the reimbursement). The information and documents to be requested from the Subject Entity may include, but are not limited to:

(1) An aged schedule of accounts receivable with payor detail for the pertinent period;
(2) Productivity reports (which reports should include admissions, payor mix, case mix, and revenue, by payor), such as incidence schedules by the appropriate reimbursement codes, for example:
   (a) Relative Value Units (RVU), for use in determining physician reimbursement;
   (b) Current Procedural Terminology (CPT) for physician procedures in both inpatient and outpatient settings;
   (c) Diagnosis Related Groups (DRG), for use in the hospital setting;
   (d) Ambulatory Payment Classifications (APCs), for use in the outpatient setting;
   (e) Healthcare Common Procedure Coding System (HCPCS), for classifying ancillary services and procedures;
   (f) Resource Utilization Groups (RUGs), for use in the skilled nursing home setting; and,
   (g) Covered lives, for use in relation to managed care companies; and,
(3) A list of any Medicare, Medicaid, and/or other third-party payor audits that have been performed or are pending for the Subject Entity, including the audit date and the outcome of the audit.

In the alternative to requesting and obtaining the data piecemeal from the Subject Entity, the analyst may request that the client, or the appropriate contact designated by the client, provide them with a "data dump" from the provider's patient billing system, which will include most of the data required to analyze the reimbursement related to the Subject Entity. Most revenue cycle software packages, e.g., Epic Systems and Meditech, allow this data to be exported to a Microsoft Excel or a data delimited (e.g., .csv) file.

Note that, quite often, the valuation analyst will sign an agreement to be a Business Associate of the client for purposes of compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).[18] Nonetheless, the analyst should request the Subject Entity that the information provided not include any protected health information (PHI), e.g., patient name, social security number, address, date of birth. The information may include the unique patient identification or medical record number, so long as it is not tied to PHI, and related to the information provided (e.g., productivity schedules).

The specific information received from the Subject Entity should then be utilized in conjunction with the general research conducted and obtained to assist in the development of growth rates and discount rates, in preparing revenue projections and other elements of the valuation analysis pertinent to the engagement.

18 The Department of Health and Human Services (HHS) defines a business associate as "person or entity, other than a member of the workforce of a covered entity, who performs functions or activities on behalf of, or provides certain services to, a covered entity that involve access by the business associate to protected health information." "Business Associate Contracts" U.S. Department of Health & Human Services, https://www.hhs.gov/hipaa/for-professionals/covered-entities/sample-business-associate-agreement-provisions/index.html (Accessed 10/27/17).

CONCLUSION

The paradigm shift in the healthcare reimbursement environment is changing the scope and nature of due diligence requests going forward. The due diligence requests have necessarily expanded to include both trends in the Subject Entity's historical financial performance and financial condition, as well as, more recently, the quality metrics that influence reimbursement rates. The dynamic evolution of the reimbursement environment has already resulted (at least in part) in healthcare transactions becoming increasingly complex and subject to emboldened regulatory review, requiring that the analyst seek and obtain robust general and specific research data in conducting a complete and thorough due diligence process (that will withstand scrutiny) related to the subject property interest being appraised, whether an enterprise, asset, or service. VE

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