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BEST PRACTICES

VOL. 19
SUMMER 2020

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FROM THE EDITOR - EDWARD McWILLIAMS, CPA

Every issue of Best Practices feels like we are continually talking about the ever rapidly changing world of healthcare practices and that was never more apparent or quicker than during the initial COVID-19 outbreak. In New York, while it felt like a long-time, we went from a scenario of *"everything is ok"* to a near 100% shutdown in a matter of only two weeks and just like that everything changed for healthcare practices.

Our Spring 2020 issue of Best Practices was immediately revamped to help provide resources for healthcare practices to cope with this *"new normal."* First, we are taking a look at a somewhat controversial but potentially helpful practice of *"zero-based budgeting."* While the concept has been taken to extremes in many organizations, the concept itself is one that should be periodically used, an evaluation and justification of all spending in a department and not just because *"we spent that much last year."*

Next, we present a guest article from one of our colleagues Pam D'Apuzzo, President of RR Health Strategies. As soon as the COVID-19 outbreak became a full crisis Pam and her team pivoted immediately to helping providers change to a virtual visit model focusing on many of the compliance-related issues practices may face. She was able to provide us with an excellent premier on the rapid launch into telemedicine that will likely still be in place even after COVID-19.

Finally, we present a guide on Consumer Driver Health Plans, which can help employers and employees reduce healthcare costs incurred. These plans are continuing to rise in popularity and their savings can be significant for employees and employers as we navigate the COVID-19 outbreak.

Above all, we got to see the heroism and dedication of healthcare providers during this outbreak. Many providers risked their lives to help others and showed the true nature of their calling as physicians and healthcare professionals and for this we are forever in your debt. It has been said many time before, but can never be said enough: **Thank you.**

CONTRIBUTORS

EDITOR

EDWARD McWILLIAMS, CPA
CERINI & ASSOCIATES, LLP
DIRECTOR, TAX

WRITERS

EDWARD McWILLIAMS, CPA
CERINI & ASSOCIATES, LLP
DIRECTOR, TAX

LAUREN GRANDINETTI
CERINI & ASSOCIATES, LLP
SUPERVISOR

PAM D'APUZZO, CPC, ACS-EM, ACS-MS, CPMA
RR HEALTH STRATEGIES, LLC
PRESIDENT

ASSOCIATE EDITOR

LULA LUKASIEWICZ
CERINI & ASSOCIATES, LLP
SENIOR MARKETER

PAGE LAYOUT & DESIGN

KRISTINA LAINO
CERINI & ASSOCIATES, LLP
GRAPHIC DESIGNER

CERINI & ASSOCIATES LLP
CERTIFIED PUBLIC ACCOUNTANTS

3340 VETERANS MEMORIAL HWY., BOHEMIA, NY 11716 | (631) 582-1600 | WWW.CERINICPA.COM

"ZERO BASED" BUDGETING FOR HEALTHCARE ORGANIZATIONS

For many organizations, the budgeting process typically relies on a baseline assumption of a dollar amount, often based on the prior years operating results, a standard increase, and then finally increases based on current year growth expectations. This process very often can be very much on *"autopilot"* without much critical analysis from department heads, the finance team and executive oversight. Over time, this mentality and approach can lead to bloat and inefficient operations for many healthcare organizations.

One tool which can be helpful to practices of all sizes can be to periodically implement a *"zero-based"* budgeting approach. Zero-based budgeting was first developed and implemented in the 1970s and then driven to extremes by investment firms such as 3G Capital in the 2000s as a tool to cut costs wherever possible and to extremes, such as focusing on such minute details as the number of pages printed and photocopies made by employees. As a result, zero-based budgeting has a reputation as an *"austerity"* measure and a tool used to cut costs to the bone. This zealous approach to the ideals may have its place in many organizations, however, the original ideals and principles of the system should be part of any organization's planning toolbox from time-to-time.

In a *"zero-based"* budgeting system, departments should look periodically at each year and budget as if starting from a zero-dollar budget allocation, rather than just what was spent in the past. ***The real point of the exercise is to take a top-down approach and determine if all spend in any given department is required to fulfill the functions of this department.*** The additional scrutiny can be used to uncover potential inefficiencies, over or understaffing in departments, discover potential synergies between departments, and empower department heads to perform an overall review of their operations.

In implanting a zero-based budgeting system, a healthcare organization should take the following steps:

1. Start a baseline zero for all departments; prior-year spending does not matter.
2. Evaluate every cost area within the department (*in conjunction with the department head*). This evaluation should include:
   a. *Required staffing to complete department functions*
   b. *Required equipment/software/hardware necessary to complete the function*
   c. *Required overhead costs needed to complete the function*

   When evaluating, consider how one would start a brand-new department from scratch. *What staffing would be required at what experience levels & salaries; what costs are required to perform the necessary operations?* The critical eye here is necessary and often best done in a collaborative effort with both an insider (*someone in the department*) and an outsider (*someone outside the department*).
3. Justify the spending in these above areas and try to identify cost savings. Some examples may include:
   a. *Looking at the cost of outsourcing billing vs. proving billing services in-house*
   b. *Staffing levels of reception/administrative staff*
   c. *Current marketing efforts and their efficiency*

   Part of any justification of spending should include an analysis of alternative possibilities (*i.e. in-house vs. outsourced billing*) and if the spending is truly necessary for the success of the organization (*such as staff lunches*). The justification does not need to be *"militant"* as often seen in zero-based budgeting systems, but rather a review of why something is important to the organization and if it should continue to be spent and allocated as part of the budget. Do not let the goal of budgeting and justification ruin the operations of the practice that made you successful in the first place.
4. Streamline and eliminate any unnecessary spending as appropriate, including looking for potential economies of scale. Many larger organizations can see a case where different departments are using similar software packages that could be cheaper with a group license as an example.

The department heads will often be the subject matter experts for the department, and their expertise should be leveraged accordingly. However, having a level of *"professional discourse"* is important and the finance team should be working with the department heads to come to the right answer. At times this will feel adversarial as there will be competing forces here of finance wanting to keep costs down but departments wanting to have as many resources as possible. ***Finding the middle ground in this process with inputs from multiple stakeholders (department head, finance and executive) is the real value benefit for organizations.***

Given that many organizations have taken zero-based budgeting to extremes and overly granular, the practice has a somewhat tarnished reputation and is often seen by many as an extreme cost-cutting move, however, the ideals of the practice on a global perspective can still offer many advantages to healthcare organizations. By starting from a zero-dollar, zero assumption base and building up departments from the ground level and requiring justification, organizations can help find cost savings or opportunities for organic growth. Focus on the point of the exercise rather than having it be an overwhelming mantra for your organization like many do. The questions should not be *"do you really need xyz?"* but rather *"why do you need xyz?,"* forcing an internal and granular look at spending patterns in departments. Organizations can sometimes find 10-15% savings by doing this and it should be part of your overall financial planning but not your organization's only financial planning tool.

EDWARD McWILLIAMS, CPA
DIRECTOR, TAX

THE POTENTIAL BENEFITS OF CONSUMER DRIVEN HEALTH PLANS

As healthcare costs continue to rise, your company may be seeking alternatives to minimize the financial strain. One effective cost management strategy is to expand your company's health insurance offerings to include a **consumer-driven health plan (CDHP)** and to promote education and awareness about the benefits of enrollment in CDHPs to its employees.

CDHPs are health insurance plans that leverage the consumer's (*i.e. employee's*) use of tax-advantaged health spending accounts to pay for health expenses, combined with a **high deductible health plan (HDHP)** that limits the consumer's out of pocket spending for medical expenses. CDHPs get their name from the need for the consumer to be actively involved in the decision-making process about what health care services they will receive, and for planning, saving, and spending for such health care services. In a CDHP, health care costs are first paid for by an allotment of money that is funded by the employee, the employer, or a combination of both, in a health spending account. Once funds from health spending accounts are depleted, the consumer is responsible for the cost of health services up to the plan's deductible. After the plan's deductible is met, the costs for health services in excess of the deductible are covered by the insurance payer in a manner that is similar to traditional health insurance plans. As with traditional plans, costs for health services in an HDHP are limited to a predetermined out-of-pocket maximum for a plan year.

One of three types of health spending accounts is typically paired with an HDHP as part of a CDHP offering. These include a **health savings account (HSA)**, **flexible spending account (FSA)**, or **health reimbursement arrangement (HRA)**. An HSA is an employee account designed to be paired with an HDHP to allow tax-free payments of current and future qualified medical expenses. Employees, the employer, or both may contribute to HSAs subject to annual IRS limits. Employee contributions to an HSA can be made pretax. An FSA is an employee account in which pretax income is saved for qualifying healthcare expenditures. Employees may contribute to FSAs subject to annual IRS limits. Employers may also contribute to FSAs. At the end of each plan year, a limited amount of unused funds may be rolled over to the next year, while the employee will lose any remaining unused balances that haven't been spent on qualified medical expenses by the end of the plan year. An HRA is an employer-owned account that is solely employer-funded. Employees are reimbursed for qualified expenses on a tax-free basis from an HRA, up to a limit set by the employer.

Consumer benefits of enrollment in CDHPs include the following:

- HDHPs generally have lower monthly premiums than traditional insurance plans, meaning the employee's contribution per paycheck to the monthly premium is generally lesser.
- Employee contributions to HSAs and FSAs are made pretax, which reduces an employee's gross income and results in tax savings for the employee.
- Distributions from HSAs, FSAs, and HRAs for qualified medical expenses are tax-free to the employee.
- Unused employee contributions to HSAs in a given year may be carried over to future years instead of being lost. Employers, at their discretion, may offer carryover of employer-funded HRA contributions.

The potential benefits of CDHP to the employer are manifold, and include the following:

- Most insurance carriers require the employer to cover a percentage of the employee-only portion of the monthly insurance premium. Since HDHPs generally have lower monthly premiums than traditional insurance plans, the employer's portion of costs per employee in an HDHP plan will, in turn, be lesser compared to a traditional insurance plan.
- Employer contributions to health spending accounts are tax-deductible.
- Offering predetermined employer contributions to health spending accounts provides a way for employers to predict and control their annual healthcare costs.
- Since participants in a CDHP are more accountable for the cost of health services, they tend to make more informed and economical decisions when accessing health services. This tends to reduce the overall cost of medical services accessed through a CDHP compared to a traditional health plan. Such cost savings are transferred to the employer by way of reduced spending of the employer contributions to health spending accounts, particularly HRAs.
- CDHPs may be preferred by employees who value more control over health care spending, are more budget-conscious, are generally healthier and therefore low utilizers of health care services, and who prefer to spend less on monthly premiums. Employers may be more able to attract and retain such employees by offering a CDHP option among its array of health care offerings.

While the potential benefits of CDHPs to both employees and employers are manifest, it is incumbent on employers to weigh all relevant factors in deciding if such a plan offering is a good fit for their company. Such factors include the number of employees, the overall health of your staff, the current and projected cost of health benefits under a CDHP versus your current plan offerings, and the desired richness of benefit. As each employee has unique healthcare needs, a one size fits all approach may not be the answer. However, including a CDHP as an alternative in your company's array of health offerings may be a win-win for both employees and the bottom line.

LAUREN GRANDINETTI
SUPERVISOR

RAPID LAUNCH TO VIRTUAL VISITS: TELEMEDICINE DURING COVID-19 AND BEYOND

There will never be a time where face-to-face visits will be obsolete, but COVID-19 has changed our world and brought a heightened awareness and acceptance of telemedicine. If your practice or organization has not mobilized virtual visits, I recommend you get on board quickly. Now is the time to evaluate and reset your practice or organization and find ways to expand your services via telemedicine.

Every life has been impacted by the COVID-19 pandemic, and all our lives have changed, but we cannot let this crisis define us. We need to define the *"new normal"* and what that will look like for healthcare patients and providers. We have learned a new way to connect through video services to our families, our friends, AND our patients. We can connect and interact with our teams and, most importantly, obtain our healthcare services. We have learned that our patients do not have to be in close proximity or mobile. Although telemedicine has been around for years, our healthcare system recently experienced a rapid launch of virtual visits. This has brought about some changes that may likely be permanent, from the newly recognized *"qualified independent healthcare providers,"* to the utilization and expansion of patients that we are able to reach, to the reimbursement policies enacted and enforced by Medicare and the federal government in response to the **public health emergency (PHE)**.

Medicare greatly expanded access to telehealth (*real-time, interactive audio/visual*) services. Patients across the entire country can now receive telehealth services in all settings, including their homes. Practitioners can provide telehealth services from their homes to new and established patients. Medicare has expanded its list of covered telehealth services and now allows a large volume of these services to be performed by telephone. These audio-only services have been expanded to include behavioral health, patient education, and counseling services. Payment for these services has been increased from the range of $14-$41 to a range of $46-$110, which is comparable to reimbursements for office/outpatient visits. This change is effective as of April 30, 2020, but retroactive from March 1, 2020, by Medicare.

In addition, the COVID-19 PHE regulatory waivers have provided significant relaxation in the guidelines including:

- **Licensure:** CMS waived the Medicare requirement that a physician or non-physician practitioner must be licensed in the State in which s/he is practicing
- **Limitations on Practitioner Type:** For the duration of the COVID-19 PHE, CMS waived provider billing restrictions for telehealth services.
- **Frequency Limitations:** CMS waived limitations on the number of times certain services that can be provided via telehealth, including subsequent inpatient visits, subsequent skilled nursing facility visits, and critical care consults.
- **Home Health Services:** Nurse practitioners, clinical nurse specialists, and physician assistants may now provide home health services.
- **Outpatient Maintenance Therapy:** CMS will allow physical and occupational therapists to delegate maintenance therapy services to physical and occupational therapy assistants working in outpatient settings.
- **Diagnostic Tests:** CMS is adding flexibility for providers (*NPs, clinical nurse specialties, PAs, certified nurse midwives*) that can furnish services directly and incident to their own services, within their state scope of practice.

Major commercial payers are initiating coverage policy changes similar to Medicare, including expanding the list of telehealth services and recognized providers, waiving originating site requirements, and waiving member cost-sharing. Check with your carriers for coverage details.

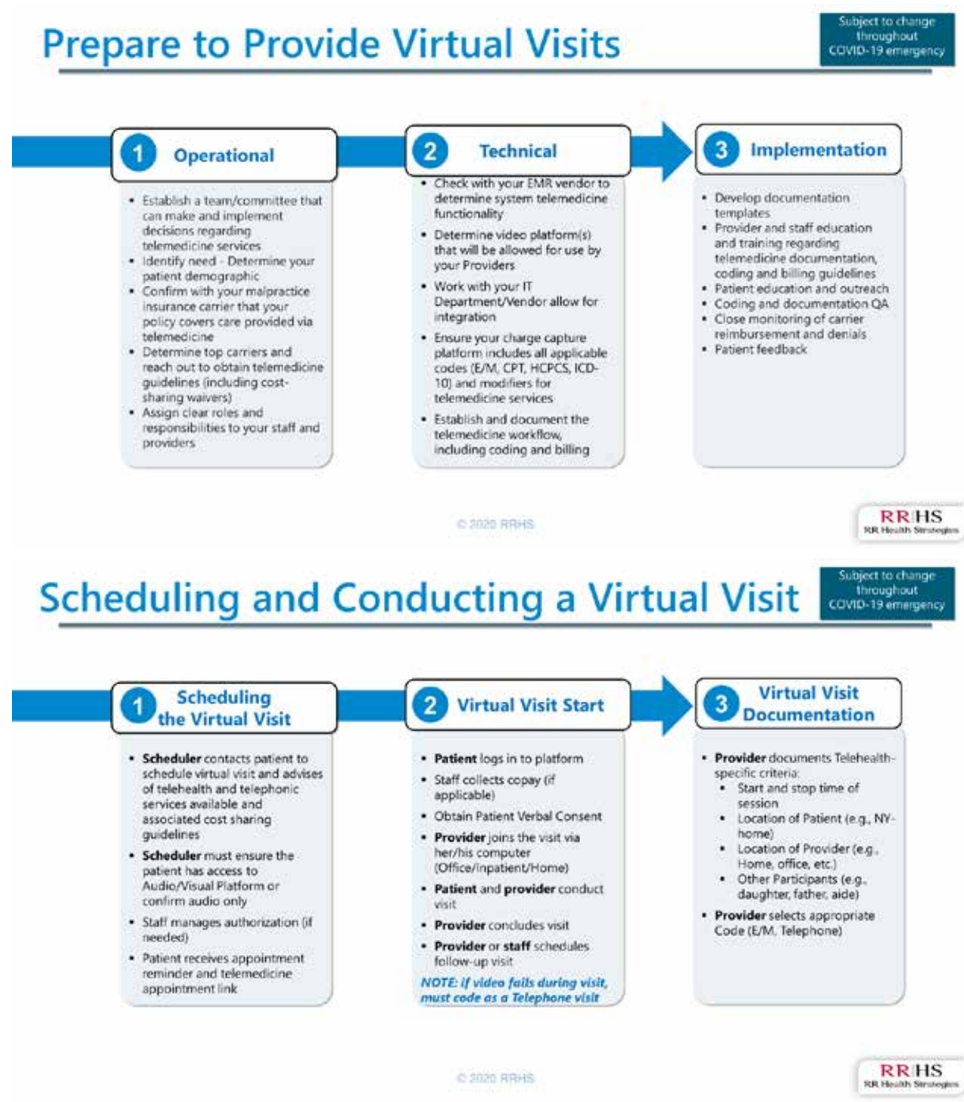
In another unprecedented action, Medicare temporarily waived the requirement for documentation of history and/or examination for an E/M service. A practitioner may use MDM or time to select the code, with time defined as *"all of the time associated with the E/M on the day of the encounter."*

- Office/Outpatient E/M Services (99201–99215) provided via telehealth- history or physical exam not required for the level of service selection.
- Provide total time spent ONLY by the practitioner (*not staff*) during the visit, whether counseling dominates the visit or not, -OR-
- Use MDM as currently defined

Practitioners should continue to be focused on appropriate documentation, coding, and billing of these services. Compliance is still in effect!

Practitioners and patients have embraced our new virtual normal. While there is likely to be some decrease in the relaxation of the guidelines and payment increases, many of these changes are projected to remain in place after the PHE. Change is only difficult if we focus on the negative, and our challenging experience is not purposeless if we can produce positive change. Telemedicine is a positive and growing medical treatment option that is here to stay! Let's reshape our vision and embrace the virtual future of healthcare.

HERE ARE SOME TIPS TO FACILITATE YOUR IMPLEMENTATION



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RR Health Strategies

PAM D'APUZZO, CPC, ACS-EM, ACS-MS, CPMA
PRESIDENT
RR HEALTH STRATEGIES, LLC

CERINI & ASSOCIATES LLP

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Cerini & Associates, LLP
3340 Veterans Memorial Hwy.
Bohemia, N.Y. 11716
www.ceriniandassociates.com

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