

Health CareRx

A business intelligence prescription for health care executives

Grant Thornton 

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Defending your prices: How hospitals can prepare for transparency

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In August 2006, President Bush signed an executive order to help increase the transparency of America's health care system. On September 12, Rep. Michael Burgess (R-Texas) introduced H.R. 6053, a

bill to "provide increased transparency of hospital information and to provide additional research on consumer information on charges and out-of-pocket costs." If it had passed before Congress adjourned, the bill would have gone into effect October 1 of this year, meaning that the government, providers, payers, employers and consumers would have had to collaborate to achieve meaningful pricing transparency. Whether

transparency will achieve its projected purposes — to help consumers spend their health care dollars wisely; to hold hospitals accountable for their prices; and, to increase competition, in turn, lowering health care costs and spending — is the subject of debate among most health care constituents.

Despite the current debate, continued action at both the state and federal levels indicates that pricing transparency is not going away. Today, nine states (Arizona, California, Florida, Louisiana, Maryland, Massachusetts, Minnesota, New Hampshire and Wisconsin) have Web-based price disclosure sites, while many other states have proposed or implemented legislative initiatives for publication of a variety of information on providers and procedures, indicating that many states are encouraging health care management teams to prepare for what is likely to become mandatory in the near future.

So what does this mean?

It is only a matter of time before health care organizations will be required to move toward meaningful price transparency, and, consequently, it is advisable to begin the process now. This means, for example, not simply providing average price-lists, but giving patients estimates — prior to service — of the total amount they will owe (out-of-pocket) for the treatment after considering the patient's specific condition and insurance coverage. >



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How hospitals can prepare for transparency (cont.)

Other suggestions to improve your pricing transparency and to develop a “meaningful” pricing policy include:

- Review and analyze your charging practices. Has your organization experienced significant charge increases from year-to-year (5% or more)? If yes, you should document what warranted these increases.
- Determine if your charges are reasonable compared to similar facilities in your labor market, state or region. If not, document why variances exist.
- Make sure your employees can educate patients on your pricing, if questioned. Consider training to educate employees and emphasize key messages.
- Consider developing marketing materials that can be used not only to explain your pricing policies, but also educate your patients on your facilities and services.
- If your organization is a not-for-profit, pay close attention to the regulations regarding maintaining your tax-exempt status. Believe it or not, prices come into play.
- Monitor your payer contracts closely, especially those payers that reimburse you on a cost basis or percent of charges basis. Make sure your organization is paying close attention to the fine print. There are health insurance companies that are including caps/limits to your pricing and, in turn, your reimbursement.

Cost segregation studies benefit health care facility owners



Warren Kitchens is a tax senior manager in Grant Thornton's Atlanta office.

Most corporate health care organizations would consider a minimized tax bill and increased cash flow a positive. Yet, most health care companies continue to cut costs without realizing that there may be opportunities to increase cash flow with their new or existing capital assets. By accelerating depreciation on reclassified assets for newly constructed projects, recently acquired properties or existing facilities, they stand to save hundreds of thousands of dollars — maybe even millions. Corporate taxpayers, particularly the owners of health care facilities, are not only

missing out on current income tax savings by under-depreciating their real estate holdings, but are also missing out on the ancillary benefits of cost segregation studies.

So why don't more organizations elect to do cost segregation studies? One simple answer is that many corporate taxpayers may not be aware of cost segregation studies. However, for those that are aware of the cost segregation study and its benefits, their reasons are more complex. For example, they may have never quantified the potential benefit or may think it applies only to new construction. They also may not realize that they can study prior years without amending their returns or may believe a study will be too disruptive to their operations. Whatever the reason(s),

the potential tax savings — and the ways in which these studies can lighten the workload when it comes to other areas of reporting — should be reason enough for many corporate health care organizations to consider hiring a professional service firm, with the requisite skill set, to maximize their profits.

“In addition to significant tax benefits, a properly assembled cost segregation study can also function as a conduit through which health care companies can capitalize their construction projects. Thousands of project line items and invoices are summarized into logical fixed assets,” said Warren Kitchens, tax senior manager in Grant Thornton's Atlanta office. “They can use these studies to set up a GAAP or book assets, use it for property tax purposes, insurable values and much more.”

“Clients may feel that cost segregation studies are a good idea, but they don't make it a priority,” said Kitchens. “However, the studies are self-funding and produce immediate benefits: tax savings and improved processes and controls for the capitalization process or fixed assets in general.”

Simply put, a cost segregation study is an asset reclassification strategy that accelerates tax-depreciation deductions. Corporate taxpayers can lower their current income tax liability and increase current cash flow by reclassifying real commercial property and personal property. Since real

Pricing transparency will help health care financial managers develop and implement more efficient billing practices. In 2000, the Healthcare Financial Management Association (HFMA) launched PATIENT FRIENDLY BILLING®, a national, industry-wide initiative to improve hospitals' financial communication with patients. To date, the American Hospital Association (AHA), the Medical Group Management Association (MGMA) and many of the nation's leading health systems have endorsed this initiative because more effective communication and billing practices can improve reputation. Consequently, price transparency can even save money. By revisiting (or developing) a pricing policy, organizations often find that they have been giving away money unnecessarily because of confusing billing practices.

Because Congress continues to introduce bills to provide increased transparency of hospital information and to provide additional research on consumer information on charges and out-of-pocket costs, the government, providers, payers, employers and consumers will all have to collaborate to achieve price transparency. So hospitals — at the very least — should be proactive and develop plans to explain to various constituents (i.e., patients, board members, donors and local political leaders) pricing decisions and cost differences. Developing strategies to respond to pricing disclosure will undoubtedly continue to be a challenge for hospitals and other health care organizations. In the long run, however, pricing transparency — along with quality patient care — will differentiate providers and, hopefully, yield a more efficient and more effective health care delivery system. ■

property is typically depreciated over 39 years (commercial property) or 27.5 years (residential property), cost classification enables organizations to accelerate depreciation, thus deferring tax payments. In effect, this creates an “interest-free loan” from the government. Properly categorizing real and personal property assets in 15, seven- or five-year depreciation lives can lead to significant federal and state tax savings.

Actual benefits derived from cost segregation vary depending on the type of property; however, health care facilities, skilled nursing facilities and assisted living facilities are usually among those that benefit most. The real or commercial property category of a typical health care facility normally includes a large amount of personal property; and, when reclassified, the depreciation deductions are accelerated and present-value tax savings increased. It is estimated that for every \$1 million in assets reclassified from a 39-year to a five-year depreciable life equates to more than \$200,000 in net present value savings. With health care facilities, it is common to classify more than 20 percent of construction costs as five-year property. This translates to a potential \$800,000 net present value benefit for a \$20 million health care expansion.

There are many assets associated with properties that may be eligible for reclassification, including certain heating, ventilation and air conditioning modifications, parking lots and sidewalks, medical gas systems, certain millwork, architectural fees and builder's profits, carpeting, nurse call systems, critical electrical systems, O.R. lighting fixtures and equipment plumbing, among many others. Amid the thousands of line items in a project cost report, there are typically many that qualify for shorter depreciable lives that equate to substantial savings.

There are, however, a series of factors that a health care taxpayer should consider before completing a cost segregation study:

1. Whether they are paying income taxes in the current year, or will be in two to three years.
2. The cost of their existing assets; \$3 million (new construction) or \$5 million (older properties) is usually a good indicator.
3. How they will complete the cost classification study — internally or externally, depending on what skills or resources are available.
4. Whether most of the benefits will come from new construction in the current year, or will the study require going back to prior years, demanding a change-in-accounting method filing.

These factors will help a corporate taxpayer decide whether a cost segregation study will be to their benefit at the time. It will also call attention to the importance of assessing the company's internal resources or the need to go outside.

“To properly assemble a cost segregation study requires specific resources, namely, individuals or a provider with both tax and engineering expertise as it relates to cost classification,” said Kitchens. “This integral skill set is needed to maximize and sustain tax benefits and meet the requirements of the IRS.” ■

Receiving pay for quality care: The future of pay-for-performance

Paying for quality care continues to take center stage with regard to health care funding in the United States. Medicare, and its Premier Hospital Quality Incentive Demonstration project, has been one of the major leaders of the pay-for-performance (P4P) enterprise, and the recent release of its second-year results indicates that there may be a paradigm shift in the near future.

Along with various P4P pilots gaining momentum across the country, the clearest indicator that P4P is here to stay is the work done by the last Congress (109th). Its move to require the Centers for Medicare & Medicaid Services (CMS) to phase in P4P measures in the Medicare reimbursement system indicates that the issue is not going away.

“Clearly, people expect quality outcomes for health care,” said Larry Goldberg, Grant Thornton’s senior advisor for health care legislative and regulatory matters. “But there is going to be a shift. Rather than providing incentives and bonuses for meeting acceptable quality

requirements, as is done now, hospitals (and eventually physicians and networks of physicians) that are not providing quality care are going to see reduced payments.”

While recent P4P studies show only modest rates of improvement (2.6 percent to 4.1 percent over two years) among hospitals required to report their quality scores compared to control groups that reported voluntarily, hospitals with the worst performance at the start of Medicare’s pilot program in 2003 improved their quality measure scores by 17.8 percent. This suggests that quality care — the kind previously rewarded with bonuses during the pilot project — will become status quo. Hospitals will no longer be rewarded financially for offering quality care but, rather, will risk receiving less government payment if they do not. The government will soon be saying, “We are paying you to do it right.” Simply put, hospitals will be expected to provide quality care, not be rewarded for it. ■

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