Trends in Long Term Care and Senior Housing

By: Kevin Kelley, Lori Duwve and Tom Vaughn

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Trends in Senior Housing Real Estate

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Some Statistics…

- In 2010, seniors aged 65+ accounted for about 13% of the U.S. population (or about 40,229,000)
- By 2030, they are projected to account for 23% of the population (or about 72,092,000)
- By 2050, they are projected to account for 29% of the population (or about 88,547,000)

Source: U.S. Census Bureau, Statistical Abstract of the United States: 2012

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Senior Housing Prior to 2008

- 55+
  - Age-restricted resorts
  - Occupancy driven primarily by consumer interests and shared activities
- Independent Living
  - Average age of ~ 75
  - Active environment
  - Very low acuity

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Senior Housing Prior to 2008

- Assisted Living
  - Average age of 80-82
  - Low acuity
- Skilled Nursing
  - Rehab residents
  - Long term care residents
  - Acuity levels based in part on third-party payor restrictions on home based or transitional care

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Senior Housing Going Forward

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Traditional or Facility Based Senior Living

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What Just Happened – 2008 through 2011

- Stock market
- Unemployment
- Housing market
- Debt and equity markets
- Home services

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Results

- More aging in place
- Drops in occupancy
- Fewer construction starts

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That Said…

- Traditional senior housing fared much better than other real estate classes
- Things are moving in the right direction for recovery
- Occupancy
- Absorption v. inventory growth
- Denver occupancy

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Demographics

- GI Generation
- Silent Generation
- Boomers

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Boomers

- Turn 65 2011 – 2030
- Turn 85 2030 – 2050

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Longer Life Plus More Aging In Place Means…

- Older residents entering traditional senior housing

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Older Residents Means…

- Higher acuity, shorter length of stay and more turnover

Higher Acuity and More Turnover Means…

- Higher operating costs and higher rents

Higher Rents and More Aging in Place means…

- Smaller pool of income qualified residents for high end market rate senior housing

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Smaller Pool of Income Qualified Residents for High End Market Rate Senior Housing Means…

- Greater emphasis on quality of product and service
- More dollars and effort must be spent on sales and marketing

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Higher Operating Costs and Higher Rents also Means…

- Greater need for options without bundled services
- Greater need for affordable product

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Skilled Nursing

- Colorado today
- Limited growth in near term
- Greater growth after 2030

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Assisted Living

- Colorado today
- Slow growth over next 20 years
- Greater growth after 2030
- Innovation and sales and marketing to become increasingly important

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Independent Living

- Colorado today
- Greater growth over next 20 years
- Amenities and location increasingly important
- Cosmopolitan Club

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Senior Apartments

- Colorado today
- Greater growth over next 20 years
- Location important

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Active Adult

- Colorado today
- Greater demand over next 20 years
- Harvard study

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Cypress Example

- Locations
- Product type – resort village

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Why Cypress Model Should Work

- Residents perspective
  - ownership
  - product type
- Operator perspective
  - debt
  - capital costs

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The Proof

- Charlotte
- Raleigh

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Memory Care

- Huge growth
  - 5.1M – 2010
  - 13.5M – 2050
- 2011 construction starts

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Other or Non-Traditional Senior Housing

- Driven by:
  - Desire to remain in one's home
  - Economic downturn and decline in housing prices
  - Cost of traditional assisted living and skilled nursing

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Co-Housing for Seniors

- Characteristics of Co-Housing:
  - Collaborative model where residents manage and perform the work of the community
  - Generally 20 to 40 dwellings
  - Orientation of dwellings around shared areas, including a "common house"
- Fair Housing Act allows 55+ restriction to include up to 20% of residents under 55

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Co-Housing for Seniors

- Residents share common goals for community and communities screen for compatibility
- Senior co-housing communities:
  - Silver Sage – Boulder, CO
  - Washington Village – Boulder, CO (under development)
  - Glacier Circle - Davis, CA
  - ElderSpirit – Abingdon, VA
  - Wolf Creek Lodge – Grass Valley, CA

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Temporary Residential Healthcare Structures

- A/K/A Alternative Dwelling Units (ADUs)
- MEDCottage
  - 288 square feet with bedroom, sitting area, bath and kitchen
  - Numerous options such as hospital beds, lifts, monitoring systems
  - Purchase or lease

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Temporary Residential Healthcare Structures

- Zoning issues may restrict location
  - In Virginia, a recent statute overrides local zoning ordinances and allows “temporary family healthcare structures” as a permitted accessory use in single-family residential zone districts
- Pacific Modern Homes
  - Kit-based models

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New Construction/Remodeling of Homes

- Universal Design
  - Design products and environments that are useable by all
  - Characterized by:
    - No steps or thresholds
    - Single-floor living
    - Wide doorways and hallways
    - Reachable controls on appliances, light switches, electrical outlets
    - Grab bars (hidden supports in new construction)
    - Higher toilets
  - CAPS – Certified Aging in Place Specialist

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CCRC Vacation Experience

- Travel network of high-end CCRCs
- Residents of participating CCRCs "vacation" at other participating CCRCs
- Assigned concierge and planner for each community
- Includes accommodations, dining, transportation, planned activities and other services

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CCRC Vacation Experience

- Communities customize their own travel packages
- Two participating CCRCs:
  - La Posada at Park Center in Green Valley, Arizona
  - The Mather in Evanston, Illinois

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Slowdown in Sales During Worst of Recession

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During Slowdown Many Deals Based on Regulatory Problems

- Under pressure for license or Medicare/Medicaid certification termination
- Sales on a short time frame

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Recent Trends

- Sales of successful properties coming back at full price
  - SNF
  - ALF
  - Independent Living

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Price Per Bed

National Average Price Per Unit

	2010	2011
IL	139,024	171,000
ALF	103,223	156,900
SNF	62,500	51,100

- Source – Senior Care Investing, March 2012

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Getting the Deal

- Competitive bidding processes
  - Confidentiality agreements
  - Preliminary due diligence information
  - Proposed letters of intent
  - Template definitive documents
  - Single or multiple “phases”
- Advantages and Disadvantages

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Confidentiality/Nonuse Agreements

- Typical Provisions:
  - Confidentiality and nondisclosure provisions and exceptions
  - Limits on use
  - Return of documents
  - Remedies

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Due Diligence – Successor Liability

- Medicare
  - 42 CFR § 489.18(c)
  - United States v. Vernon Home Health Care, Inc., 21 F3d 693 (5th Cir. 1994)
  - Deebrook Pavillion v. Shalala, 235 F3d 1100 (8th Cir. 2000)
- Medicaid
  - Overpayments
  - Provider taxes

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Due Diligence – LTC

- Due diligence for LTC includes
  - Anti-Kickback Law, 42 U.S.C. § 1320a-7b
  - Any state anti-kickback laws and other state fraud and abuse laws
  - Stark II, 42 U.S.C. § 1395nn(a)(1) and (2)
  - Any state anti-referral law
  - False Claims, 42 U.S.C. § 1320a-7b
  - Civil False Claims Act, 31 U.S.C. § 3729
  - Civil monetary penalties, 42 U.S.C. § 1320a-7b

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Due Diligence – LTC

- Status of Nursing home license
- Status of Medicare and Medicaid certification
  - Open cost reporting periods
  - Unpaid provider taxes
  - Life Safety Code
- Certificate of Need
- State Medicaid bed moratorium in Colorado
- Other Licenses and permits

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Independent Living v. Licensed Care

- Extra Services
- By IL operator
- By affiliate

Does operator need a LTC license under state laws?

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Medicaid Provider Agreements

- How does buyer apply for Medicaid? Transfer or new agreement? Is there Medicaid successor liability?
- When will buyer be approved for Medicaid? Buyer and lender need to understand the Medicaid process since Medicaid may be bulk of facility revenue
- Include licensure and certification contingency in every letter of intent

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Medicare Provider Agreements

- Will the provider agreement be assumed
  - Assumption of seller's Medicare liabilities for repayments, CMPs and other liabilities
  - Interrupted cash flow/non-payment for services rendered
  - CMS 855A asks whether new provider is accepting assignment of the prior provider's provider agreement

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Medicare Provider Agreements

- Can you "reject" existing provider agreement?
  - Old operator must withdraw from the program
  - New owner is a new Medicare provider, e.g., go through initial Medicare certification process, be deficiency free, etc.
  - Expect to wait months

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CMS 855A Form

- File the CMS 855A form as soon as possible with the proper fiscal intermediary
  - Both buyer and seller file 855A in a CHOW
  - Fiscal intermediary has sixty (60) days
- Assignment is not complete until a "tie-in" notice is issued (60 – 90 days or more)
- If buyer accepts provider agreement, approval is retroactive to the effective date, but claims may need to be held for many months

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HIPAA

- Providers can disclose PHI in connection with "Health Care Operations"
- "Health Care Operations" includes the "sale, transfer, or merger…of the covered entity…and due diligence related to such activity"
- No resident consent is required
- Buyer and Seller should enter into a business associate agreement

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Title Insurance Issues

- Definition of "permitted exceptions"
- Limitations on the title
- General warranty deed, special warranty deed or only a quit-claim deed
- Will title insurance company agree to insure a special warranty deed or quit-claim deed?
- Who pays for the title insurance commitment, owner's policy, and lender's policy?
- Kind of title policy required and endorsements

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Environmental Audit

- Phase I may be satisfactory
- ASTM developed a set of standards
- Buyer or lender require anything in addition to Phase I?
- Who pays for environmental audit?
- Time for buyer to terminate if buyer does not like audit
- Does buyer have complete discretion to terminate?

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Indemnification

- By seller for preclosing items
- By buyer for postclosing items
- Claim procedure
- Legal fees and costs
- Threshold or “basket” before claims can be asserted
- Time limit for filing claims
  - Some restrictions on contractual status of limitations
  - Other ways limiting the duration of warranties
- Maximum dollar amount of claims
- Environmental matters

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Handling Healthcare Arbitration Effectively

By: Angela Quinn and Katie Reilly

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Potential Benefits of Arbitration

- Faster Dispute Resolution
- Less Expensive

AAA Healthcare Claims	Median Timeframe
$1M+	16 months
$500K - $1 M	13.5 months
$75K - $499K	9.3 months
Under $75K	5.4 months
U.S. District Court (All Cases)	23.3 months

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Best Practices for Effective Healthcare Arbitrations

- Is Arbitration the Right Tool – Issues to Consider
- Administrative Organizations
- Drafting the ADR Clause

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Arbitration Checklist Issues to Consider

1. What does the potential dispute relate to or involve?
   - Bet the Company litigation
   - Pattern litigation
   - Peer Review
   - Provider Termination
   - Credentialing Dispute
   - Reimbursement Dispute
   - Class Action
   - Subject matter complexity

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Arbitration Checklist
Issues to Consider

2. After considering #1, consider:
   - Confidentiality
   - Speed to resolution
   - Cost
   - Amount at stake
   - Limited Rules of Evidence

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Arbitration Checklist
Issues to Consider

- Potential for compromise verdict
- Appeal rights limited
- Rules of procedure limited
- Can become like court litigation absent smart dispute resolution clauses
- Summary disposition generally unavailable

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Healthcare Disputes are Unique

- Complicated regulations
- HIPAA and patient confidentiality
- Panel expertise
- Rules of Evidence
- Can gain efficiency through consolidation

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Administrative Organizations

- AAA Health Care Industry Rules
- AHLA ADR Service
- JAMS
- Local ADR Services
- Do you need administering organization?

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AAA Healthcare Payor Provider Arbitration

- Payor – e.g., insurers, HMOs
- Provider – e.g., hospital, doctors
- Not available for medical malpractice claims
- Permit all claims and counterclaims between a payor and a provider to be combined in a single arbitration
- Arbitrations by single arbitrator unless the parties otherwise agree
- AAA has designated subset of arbitrators with expertise in payor-provider disputes

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AAA Healthcare Payor Provider Arbitration

- Parties choose one of three administrative procedures/tracks:
  - Desk/telephonic track – no discovery or depositions without good cause shown
  - Regular track – limits depositions to one per party with additional depositions considered based on good cause shown
  - Complex track – limits depositions to two per party with additional depositions considered based on good cause shown

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AAA Healthcare Payor Provider Arbitration

- Mandatory preliminary conference to be held regardless of track selected. Arbitrator is given authority to resolve preliminary issues at that conference.
- No dissemination or publication of the arbitration award unless parties agree in writing

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AHLA Dispute Resolution

- The American Health Lawyers Association Alternative Dispute Resolution Service (Service) offers various alternative dispute resolution services specifically designed for members of the healthcare industry and those associated with it
- An important feature of the Service is the establishment and maintenance of panels of trained healthcare arbitrators, mediators, hearing officers and other dispute resolvers

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Considerations in Drafting the ADR Clause

- Draft and modify arbitration clause to reflect the intent of the parties with respect to arbitration. Tailor the clause to suit your objectives.
- Binding or non-binding
- Scope of arbitration (may limit to just contractual or include tort claims)
- Administering Organization

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Considerations in Drafting the ADR Clause

- Place, time and date of arbitration
- Applicable law
- Number and qualifications of arbitrators (specify panel expertise)
- Method of arbitrator selection
- Payment of costs

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Considerations in Drafting the ADR Clause

- Discovery (limit types of discovery, time period which parties may conduct discovery)
- Relief/Altering Damages/Altering Remedies (no punitive or consequential damages)
- Standard of proof
- Order and Manner of Proceedings (witnesses, evidence, exhibits)

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Considerations in Drafting the ADR Clause

- Fast track arbitration
- Reasoned Award
- Vest question of arbitrability with Panel
- Ex Parte Communications
- Negotiation-Arbitration Clause
- Mediation-Arbitration Clause
- Stepped Negotiation, Mediation, Arbitration, pre arbitration dispute mechanisms

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Considerations in Drafting the ADR Clause

- Interim or Emergency Relief
- Confidentiality
- Class Waiver
- Time Bar Claims
- Carve out Bet the Company Disputes, disputes with well developed law, and emergency relief
- Damage Limitations no punitive or consequential damages

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Colorado HCAA

Arbitration agreements between healthcare providers and patients:

- Must contain statutory arbitration language – CRS 13-64-403(3)
- 90-day rescission right
- Cannot refuse medical care services because patient refused to sign arbitration agreement or exercised rescission right

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Takeaways

- Arbitration can be as expensive as litigation
- Arbitration also has the potential to be infinitely more efficient and cost effective
- Often more engagement on the part of the neutral compared to a state court or federal judge
- Have opportunity to select neutral who has healthcare expertise

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Takeaways

- The expense / efficiency of arbitration largely is dictated by whether the arbitration agreement is specific and tailored
- Healthcare entities would greatly benefit from more thought on drafting arbitration provisions on the front end of contractual relationship and again at the onset of the dispute

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You've Inherited a Problem: Strategies for Handling Complex Physician Contracting Integration Compliance Challenges

By: Curt Chase and Dan Stech

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Objectives

1. Explore common hospital / physician relationships that generate serious and complex compliance issues
2. Discover methods for effectively auditing, managing and conducting internal investigations
3. Assess the financial and compliance implications of physician arrangements
4. Evaluate disclosure options and appropriate fixes
5. Review and discuss case study

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Objective One

Explore common hospital / physician relationships that generate serious and complex compliance issues

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Common Relationships

Traditional	Unique	Emerging
• Employment • Medical Directorship • Call Coverage • Independent Contractor • Recruitment • Medical Staff Leadership • Mid-Level Supervision • Leases	• Professional Services Arrangements (PSA) • Co-Management Arrangements • Income / Revenue Guarantees • Uncompensated Care • Management Services Arrangements (MSA) • State/county subsidies to physicians through hospitals, etc. • GME / Teaching Programs and Resident Supervision	• Research Relationships • Technology: Meaningful Use / CPOE / EHR Champions • Specialty Clinics (e.g., wound care, vein, outreach, etc.) • Shared savings and bundled payments • Risk-Sharing Arrangements • ACOs

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Governing Laws

- There are a number of laws that impact hospital-physician relationships
  - Anti-Kickback Statute (AKS)
  - False Claims Act (FCA)
  - Corporate Practice of Medicine Statutes (CPOM)
  - Stark Law ($&!^#)

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Stark Law

- Stark prohibits
  - physicians
  - from making referrals
  - of designated health services
  - to an entity
  - with which the physician has a financial relationship
- The statute is so broad that it covers nearly any physician-hospital arrangement. Therefore, it is critical the arrangement meets one of the Stark exceptions.
- Common exceptions include: employment; personal services contracts; leases; etc.

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Anti-kickback Statute

- The AKS prohibits the offer, payment, solicitation, or receipt of any remuneration (directly or indirectly) in exchange for--or to induce--referrals
- Unlike Stark, which is a strict liability statute, the AKS is intent-based
  - In many jurisdictions, the intent requirement is met if any one purpose for the remuneration is in exchange for referrals (the "one-purpose test")

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False Claims Act

- Prohibits one from knowingly submitting a false claim to the Government in order to obtain payment
- Also prohibits the knowing retention of money obtained from the Government to which one may not be entitled ("reverse false claims")
  - Note that "knowing" and "knowingly" encompass actual knowledge, deliberate ignorance, and reckless disregard of truth or falsity
  - No specific intent requirement
- The discovery of contracts that trigger Stark or AKS liability also creates FCA liability if the resulting overpayments are not disclosed or repaid within 60 days of identification of the issue

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Elements of a Compliant Physician Relationship

- Stark exception or AKS safe harbor is identified and followed
- Agreement in writing
- At least one-year term
- Compensation set in advance
- Compensation not tied to referrals (past, present or future)
- Compensation is fair market value and commercially reasonable

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Potential Sources of Problems

Contracts	Documentation	Payments	Non-Monetary Compensation
• Unsigned contracts • Late signatures • Missing contracts • Insufficient contract language • "Rogue" contracts • Expired contracts	• Lack of documentation • Insufficient documentation • Missing documentation • Documentation not consistent with payment • Simple clerical errors (calculations, wrong payee name, etc.)	• Payment not consistent with contractual parameters • Payment for services not rendered • Overpayments, underpayments, etc.	• Provision of non-monetary items of value not accounted for or that exceed the annual CMS limit.

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Objective Two

Discover methods for effectively auditing, managing, and conducting internal investigations

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The Audit Process

- Aspects of an ongoing physician payment audit process to consider:
  - Pre-Payment
  - Ongoing Monitoring
  - Post-Payment

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Pre-Payment Controls

Role of the Compliance Officer in Physician Contracting

- The Compliance Officer **should not** be directly involved in negotiating contracts with physicians in order to ensure independence of payment review throughout the contract term.
- The Compliance Officer **should** ensure that the appropriate controls are in place to govern the physician contracting process.

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Pre-Payment Controls – 1

- Pre-Payment Controls
  - Written agreements are in place
  - Appropriate contract language review is conducted
  - FMV analysis policies and practices are performed
  - Operational compliance (i.e., payment timing, documentation requirements, etc.)
  - Payment controls are in place
  - Routine post-payment auditing processes are established
  - Signatures are appropriately obtained timely
  - Documents are properly maintained

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Pre-Payment Controls – 2

- Before making physician payments:
  - Who processes requests for payments to physicians?
  - Do they have adequate knowledge of the contract parameters?
  - Are the proper forms used (i.e., activity logs, time sheets, invoices, check requests, receipts, etc.)?
  - Is the payment consistent with the contract?
  - Are the appropriate authorized signatures on payment requests?
    - What about signature stamps? What about photocopied activity logs/time sheets or invoices?
  - Are reimbursement for business expenses allowed? If so, are they consistent with contract or organizational policy?

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Pre-Payment Controls – 3

- Before making physician payments:
  - Question your organization's level of scrutiny – are you really looking closely at invoices/time sheets before paying? Does everything add up?
  - Warn against "signature fatigue" (i.e., authorized individuals who sign so many documents they no longer care what is placed in front of them).
    - What does a signature truly represent?
  - Is there a stop-gap reviewer before the payment request goes to accounts payable? 100% of payments? Spot checks?

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Ongoing Monitoring

- Is there a prospective process for approving payments (operations, compliance, finance, internal audit, etc.)?
- Who tracks annual payment maximums or minimums?
- Who tracks annual work requirement maximums or minimums?
- Who conducts periodic reconciliations for income guarantees?
- Who monitors allowable business expense annual maximums?
- What about “contract creep”?
  - Do the services described in the contract still represent the services actually being rendered? Has something been added, modified or removed? Were any changes reflected in the agreement or by addendum? Does payment still reflect FMV for services rendered?

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Post-Payment

- What is your ongoing audit process?
- Is there a retrospective process for reviewing payments (operations, compliance, finance, internal audit, etc.)?
- Scheduled periodic reviews? Sampling?

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Auditing Considerations

- Auditing of physician arrangements should be a core compliance initiative.
- Proceed, but with caution.
- Keep scope of audits contained – don't try to audit everything at once.
- If you pick up a stone, you have to be prepared to deal with whatever is under it.

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Objective Three

Assessing the financial and compliance implications of physician arrangements

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Value Drivers in Representative Arrangements

Employment	Professional Service Arrangement	Emergency Call

• Prevailing specialty compensation
• Amount and type of physician work
• Physician qualifications / experience
• Market factors
  • Recruitment / retention
  • Supply and Demand
  • Competition
  • Payer Climate
	• Prevailing specialty compensation
	• Amount and type of physician work
	• Physician qualifications
	• Market factors
	• Expense considerations
		• Prevailing specialty compensation
		• Call Requirement (unrestricted or restricted)
		• Number of participating physicians and burden of call
		• Intensity of Call
		• Payer Mix
		• Hospital trauma designation
		• Market factors

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Commercial Reasonableness

- Required, but not defined in Stark or AKS
- CMS Definition
  - *An arrangement that appears to be a sensible, prudent business agreement, from the perspective of the parties involved, even in the absence of any potential referrals.*
  - *"An arrangement will be considered 'commercially reasonable' in the absence of referrals if the arrangement would make commercial sense if entered into by a reasonable entity of similar type and size and a reasonable physician (or family member or group practice) of similar scope and specialty, even if there were no potential DHS [Designated Health Services] referrals."*
- Heightened concern as a result of Toumey and Halifax cases.

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Commercial Reasonableness: A Practical Concern

- *"A payment term may be deemed to be fair market value, but may not be commercially reasonable."*
- Examples:
  - Paying a physician for a medical directorship that the hospital doesn't need, or for work that another physician is already performing.
  - Leasing 3,000 square feet from a physician-owned MOB when the hospital only needs 1,500 (and vice versa).

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Evaluating and Documenting Commercial Reasonableness – 1

1. What is the hospital's specific purpose for contracting for the services or conducting the transaction?
2. Does the arrangement meet the need/demand for the services of the hospital and surrounding community? Is there any objective data available that indicates a hospital and community need for these specific services?
3. Absent patient referrals, what benefits do the hospital and community receive from the arrangement?
4. Does entering into the arrangement solve or prevent an identified business problem for the hospital?
5. Are the terms of the arrangement sensible and consistent with accepted business practices?
   - Factors to consider include: duration, renewal, termination, compensation review and other relevant contractual terms.

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Evaluating and Documenting Commercial Reasonableness – 2

6. Is the arrangement explainable? In other words, on its face, is the arrangement clear and are the tasks, duties, and responsibility expectations clearly articulated and documented?
7. Absent patient referrals, does the agreement make economic sense for both parties?
8. Is the arrangement consistent with other arrangements of similar nature observed in the industry?

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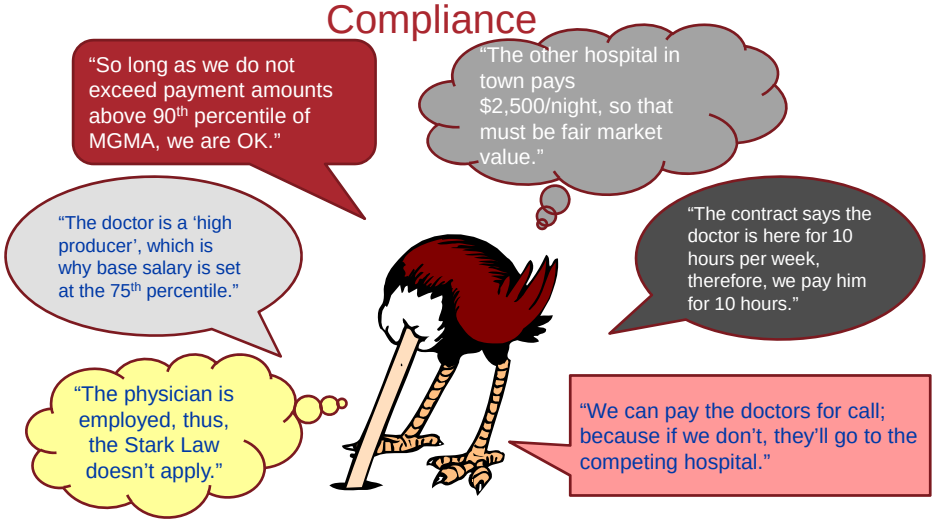
Top Misconceptions in Physician Compensation Compliance



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Audit Recommendations for Physician Compensation Plans

1. Ensure contract is current
2. Identify compensable activities described within the contract
   - Are the activities being performed?
   - Are related payments consistent with contract terms?
3. Review compensation methodology
   - Are physicians being compensated for inappropriate revenue or activity (modifiers and mid-level providers)?
4. Evaluate aggregate compensation
   - Total from all sources (i.e., clinical pay, sign-on bonus, medical directorship, call, etc.)
   - Ensure total compensation is within FMV
5. Is documentation of FMV and commercial reasonableness included in the contract file?
   - Consider an FMV review trigger or compensation cap for highly compensated physicians, especially in connection with production-based compensation plans

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Objective Four

Evaluate appropriate fixes and disclosure options

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Resolving the Problem – 1

To Disclose or Not To Disclose:

That is the Question

Options:

- Fix issue and move on?
- Repay the money at issue?
- Disclose to a federal agency or law enforcement?

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Resolving the Problem – 2

Option 1 - Fix and move forward

- False Claims Act requires an affirmative repayment within 60 days of any claim identified as an overpayment
- Stark Law violations are deemed to result in overpayments
- Therefore, the fix and move forward option is no longer an acceptable fix
- No exceptions for technical errors

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Resolving the Problem – 3

Option 2 - Repay the money at issue

- If amounts are small, just repay Medicare program

- Analysis and issues to consider:
  - What is the "period of disallowance"?
  - How much is at stake?
  - How far back does issue go?
  - What red flags will a repayment make?
  - Can you really determine which claims are at issue?
  - What are the costs (legal, consulting, internal)?

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Resolving the Problem – 4

Option 3 – Disclose to a federal agency or law enforcement

- Disclosure Options
  - OIG
  - CMS
  - DOJ
- What is the process and how to choose?
  - Stark-only violations disclosed to CMS
  - Stark and kickback violations disclosed to OIG or DOJ
- Analysis and issues to consider:
  - How serious is the issue? How systemic?
  - Is the organization prepared for the process and uncertainty?
  - What are the costs (legal, consulting, internal)?

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Objective Five

Review and Discuss Case Study

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Case Analysis – Phase I

- You receive a call notifying you that some payments have been made incorrectly under a medical director agreement.
- How should you proceed?

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Key Questions

- Are you on notice to investigate?
- Do you spot check some other agreements?
- What is an appropriate process to follow?
- Do you get legal involved?
- Should you also look at contracts that are no longer current?
- How far back should you go?
- Move to next phase…

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Case Analysis – Phase II

- You investigate, and decide to spot check a few other agreements to make sure the payment error is not systemic. Following your spot check, you uncover a number of other issues:
  - Several unsigned contracts
  - Some missing contracts
  - Payments for services not rendered
  - Ongoing overpayments under certain contracts
  - Payments being made without sufficient documentation
  - At a glance, some contracts' compensation seems high and there is no FMV language or documentation
- Now what?

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Key Questions

- Auditing questions
- Does legal need to be involved?
- What should be done about missing contracts?
- What is the validity of a historical FMV analysis?
  - Discuss pros/cons of a retrospective analysis
  - Actual production less than assumptions
- Have you now "identified" an overpayment?
  - When does 60-day clock start?
- At what point is there a disclosure or repayment obligation?

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Case Analysis – Phase III

- Concerned that the trouble is not just limited to employment contracts, PSAs, and the medical director agreement, you begin to look into lease arrangements and find:
  - Unwritten leases
  - A physician group is using x sq. feet when the lease stipulates y sq. feet
  - A few old leases contain a nominal rent amount, such as $1
- Besides quitting your job or filing a *qui tam* whistleblower lawsuit, what are your options? How should you proceed?

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Key Questions

- Do other arrangements need to be reviewed?
- Does legal need to be involved?
- What are the disclosure options?
- Has the 60-day disclosure period expired?
- How deep of an accounting system review is necessary to identify historic payment methods?
- Disclose or repay?

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Compensation and Bundled Payments

By: Winn Halverhout, Lucas Hutchison and Anthony Long

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Compensation and Bundled Payments

By: Winn W. Halverhout

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Setting the Stage

- "The New Performance Standard"
  - State budget crises forcing radical changes in Medicaid programs
    - Cut rates, limit services
    - Outsource program operations
    - Compel provider innovation
  - Accountable Payment Models
    - Bundled pricing/payments
    - P4P
    - Shared savings

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Setting the Stage

- "Compliance Challenges in Physician Compensation and Integration"
  - Emerging hospital/physician relationships can generate serious and complex compliance issues
    - Shared savings and bundled payments
    - Risk sharing arrangements
    - ACOs
  - Halifax and Tuomey

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Recent Test Drives with Accountable Payment Models

- CMS ACE Demonstration Projects
- Gainsharing
- ACOs
- Capitation – Déjà vu all over again?

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Medicaid Managed Care – The Rage

- States looking to shift premium funding risks and outsource administrative duties to commercial managed care plans
- Managed care plans bidding aggressively for these contracts while shifting risk to providers
- Capitation is a popular mechanism to shift risk
- Commercial plans looking beyond Medicaid

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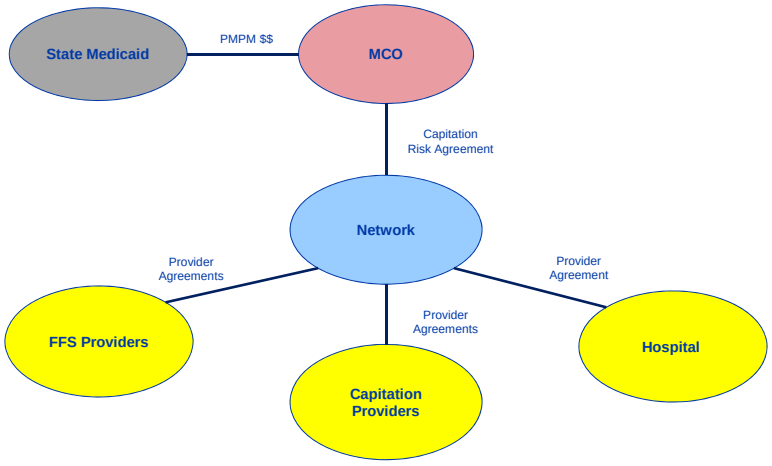
"Simple" Model



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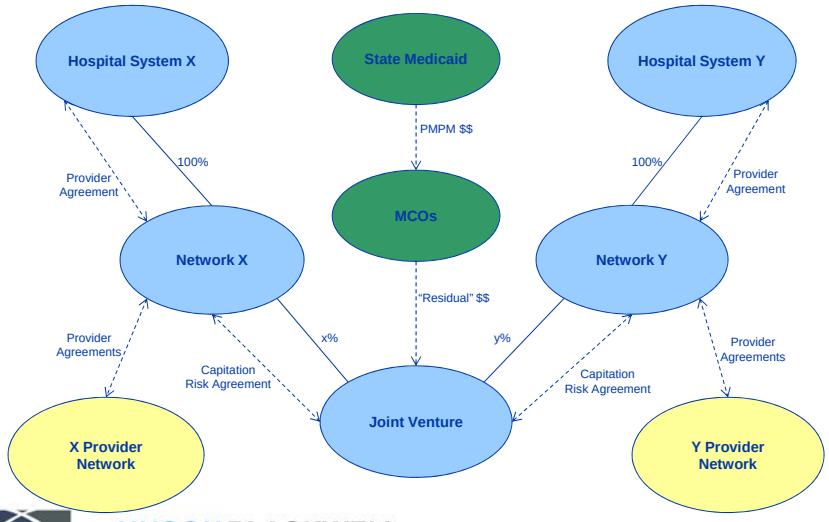
JV Model



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Bundling Defined

- Combined payments for physician, hospital and other provides into a single payment of a PREDETERMINED amount for all services furnished
  - Rationale is that paying once for all services associated with a procedures will produce improvements in care delivery while reducing cost to payors and patients alike
  - Already used in transplantation services
  - Need to solve disconnect among multiple providers in understanding each reimbursement and pay system involved

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Prior Bundled Demonstrations Projects

- Projects
  - Medicare Participating Heart Bypass Center demonstration
  - Medicare Cataract Surgery Payment Alternative demonstration
  - Medicare Acute Care Episode (ACE) demonstration
  - Physician Hospital Collaboration demonstration
  - 2005 Deficit Reduction Act (RDA) Medicare Gainsharing demonstration
- Outcomes / Findings
  - Participating Heart Bypass demonstration – savings
  - Cataract Surgery Payment demonstration – standardization of physician behavior and increases in efficiency
  - ACE – CMS savings and hospital savings and improved quality and patient experience

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Drilling Down into Bundling

- Designing a bundling compensation system
  - Design elements
  - Financial model elements
  - Organizational/operational elements
- Prioritizing the opportunities
- Understanding the dynamics

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Drilling Down into Bundling

- Types of bundling arrangements
- Types of physician arrangements affected
- Impact of bundled payments on physician relationships
- Strategies to achieve desired alignments with physicians
- Success factors

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Drilling Down into Bundling

- Contracts become more complex
  - Multi-party relationships impacting two-party agreements
- More regulators now interested
  - Antitrust
  - State insurance regulation
- Present panoply of healthcare compliance concerns still remain

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Questions?

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Bundled Payments and Physician Compensation

By: Lucas Hutchison

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Bundled Payment Types Affecting Physician Compensation

- Payments for Episodic Care
- Payments for Population Management
- Any payment mechanism that combines payment for physician professional services with other payments:
  - Facility fees
  - Pharmacy costs
  - Laboratory
  - DME
  - Etc.

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Types of Physician Relationships Affected

- Employed physicians
- Community physicians with established contractual relationships (PSA, other independent contractors)
- Community Physicians without established contractual relationships

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Impact of Bundled Payments on Physician Relationships

- Shifting of the risk profile
  - Which party takes more (Hospital/System or Physicians)?
- Shifting of incentives in care delivery
  - Financial
  - Utilization
  - Quality of Care
  - How much impact do shifting incentives have on care delivery?
  - How much impact do shifting incentives have on relationships with physicians?

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What is the Impact of Bundled Payments on Physician Relationships?

- Physicians increased impact on financial success/failure of bundled payment initiatives
- Increased importance of structure of compensation arrangements with physicians
  - Employed Physicians
  - Community Physicians
- Aligning Incentives Critically Important

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What Should Your Physician Relationships Look Like?

- Ideal Compensation Structure needs to recognize:
  - Bundle incentives (both explicit and inherent)
    - Metrics impacting bundle payment
      - Quality of care standards
      - Volume (not in the traditional fee for service sense)

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What Should Your Physician Relationships Look Like?

    - Metrics impacting financial success
      - Utilization/cost of care
      - Readmissions
- Shared risk
  - Physician compensation variable depending on important bundle metrics
- Shared success

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Important Considerations – Employed Physicians

- Type and size of employed physician group(s)
- Compensation philosophy of organization
  - Base/guaranteed salary focused
  - Heavy focus on production incentives (collections, WRVUs, etc)

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Important Considerations – Employed Physicians

- Process for changes in compensation plan
  - History of prior changes
  - Impact on physicians outside bundle
  - Politics of changes in compensation plan design
  - Legal parameters of changes in compensation structure
- Impact of performance of non-employed physicians
- Physicians' resistance to placing compensation at risk
  - How quickly can incentives be aligned?

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Important Considerations – Non-Employed Physicians

- Nature of current contractual relationships:
  - Which physicians/groups are aligned?
  - Current payment structure
  - Barriers to altering contractual relationship (political, strategic, legal, etc.)

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Important Considerations – Non-Employed Physicians

- Aligning physicians from disparate groups under the same contractual framework
  - Different physician organizations
  - Different physician specialties
- Physicians' resistance to placing compensation at risk
  - How quickly can incentives be aligned?

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Strategies to Achieve Desired Alignment

- Consider physician compensation early in the bundle planning phase
  - Involve key physician(s) early
- Develop a progressive compensation plan
  - With time compensation becomes increasingly impacted by measurable metrics

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Strategies to Achieve Desired Alignment

- Compensation plan should be clearly developed and tested when proposed
  - Metrics and timing should be clearly defined
  - Performance scenarios developed to aid in discussing potential impacts on compensation payments
  - Evaluation of baseline performance critical to usefulness of performance scenarios

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Success Factors – Alignment of Physician Compensation

- Infrastructure is critical:
  - Ability to measure and report performance metrics (timeliness and accuracy)
    - Cost of care metrics
    - Quality metrics
    - Measurable at individual and group physician level

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Success Factors – Alignment of Physician Compensation

- Pace at which alignment can be achieved
  - Will largely impact financial risk of the organization
- Continued alignment with broader organizational goals:
  - Volume/patient base
  - Education/training
  - Research
- Where does the leverage lie in the discussions?

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Questions?

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Key Considerations for Approaching Changes in Reimbursement Models

By: Anthony Long

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Common Questions

- Bundle Design Elements
  - What services (e.g., imaging, lab, SNF, procedure, etc.) and time windows should be included in which bundles (e.g., cardiac, orthopedic, etc.)?
  - Which providers should be included and why?
  - For example, for models that include post-discharge services, how should post-discharges be defined and for what period of time?

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Common Questions

- Financial Model Elements
  - What discount rate should be phased in over time, mindful of any cost/expenditure target?
  - How should you propose to design its gain sharing arrangement over time?
  - How should the bundles be risk adjusted?
  - How should anticipated coding changes impact performance vs. the proposed discount?
  - How should we manage the financial risk? Stop loss? Etc.?
  - What's the gain sharing model?

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Common Questions

- Organizational/Operational Elements
  - How to administer/pay bundles (FI, ASO)?
  - How should progress be monitored over time vs. the proposed discount and vs. required quality indicators? What metrics should be used to project variances from expected early enough to affect change?

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Prioritization Framework

- Establish a framework for identifying bundled payment opportunities

- Opportunities scored using a combination of internal detailed claims and publicly available data

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Understanding the Opportunities

- Analytic Opportunities
  - Confirm quality and cost savings opportunities through deep dive analyses
  - Develop plan to improve quality and affordability

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Understanding the Opportunities

- Bundle Design Opportunities
  - Help lead developing and standardizing the clinical guidelines, protocols, pathways and order sets for key services
  - Then to design the gain sharing model, including key metrics to be used to monitor quality and affordability so we can share in the results
  - Partnership requires transparency in data, new forums for communicating, and a relationship built on trust and collaboration

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Hospital – Physician Relationship Changing

- While the model has been outlined by CMS, the financial aspects do not make the relationships easier
- Care Coordination moves from the In-Patient only evaluation to the OP and ED Visit

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Hospital – Physician Relationship Changing

- Sitting across the table from a physician requires:
  - Education
  - Ability to engage a Physician-Led Process
  - Model for Transparency in Competitive Environment
  - Understanding how to 'value' each contributor
  - Establish clear and concise approaches for win-win

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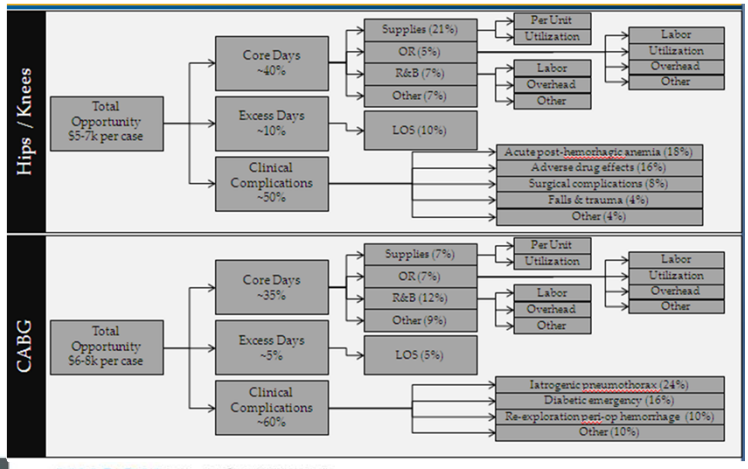
Sample Analytics

- Sample: IP Drill Down Alternative View



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Hospital-Physician Relationships Changing

- Medicare pilot project provides the incentives for Hospital + physician partners to work together
  - Allows Hospital + physician partners to design joint and spine bundles based on 2009 'episode payment' (Hospital facility fee + professional fee)
  - Pilot allows Hospital + physicians to share in improvements

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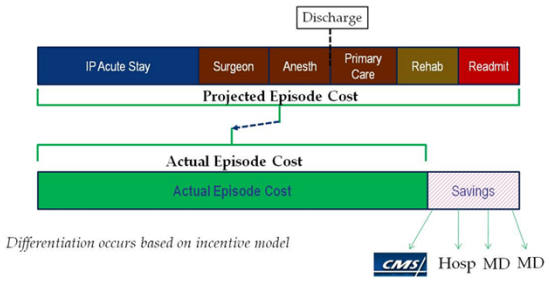
CMMI Bundled Payment Initiative

- If together we can reduce cost (unit input cost and/or readmissions), we can share the savings.
- However, participation requires 3% discount to Medicare.



If we can reduce episode costs, we share the savings.

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