

THE NEWSLETTER FROM THE BDO CENTER FOR HEALTHCARE EXCELLENCE & INNOVATION

# BDO KNOWS HEALTHCARE



## A SEA CHANGE IN REIMBURSEMENT PARITY FOR BEHAVIORAL HEALTH

By William Bithoney, MD, FAAP, and Rachel Lauren, The BDO Center for Healthcare Excellence & Innovation

The behavioral health market has been undergoing a transformative shift making it ripe for growth and consolidation. With the sheer volume of patients now insured for behavioral health needs outpacing the availability of services to treat them, investors foresee compelling opportunities to enter the marketplace. Recent developments continue to set the stage for opportunity.

Underlying these occasions for investment and expansion is a subsector of healthcare that has often faced low reimbursement rates and lack of payment for behavioral health interventions. In 2008, Congress took a proactive step to address these issues and passed the Mental Health Parity and Addiction Equity Act (MHPAEA). It mandated that behavioral health issues and medical issues be treated under the same terms and conditions

when covered by health insurers, and later revisions to the act required most insurance plans cover mental health and substance abuse services. Also in 2008, Congress passed the Medicare Improvements for Patients and Providers Act (MIPPA), which increased access to mental health in federal programs. In 2013, Congress issued clarifying legislation imposing penalties and sanctions on insurers that did not comply with these requirements. This spate of legislation was a welcome change for patients, mental health professionals and healthcare providers.

Less discussed, however, is the salutary effect this legislation will have on investments in behavioral health. The MHPAEA has resulted in a sea change breakthrough in reimbursement. This improved reimbursement has already resulted in an increase in investment activity in the behavioral health arena, especially in

### CONTENTS

- A Sea Change in Reimbursement Parity for Behavioral Health ..... 1
- DSRIP in New York: Leading the Value-Based Healthcare Workforce Strategy Evolution ..... 3
- New Payment Models Bring New Healthcare Data Measurement Requirements ..... 4
- Evolving Portfolio and Real Estate Strategies in U.S. Healthcare Systems: The Rise of Outpatient and Ambulatory Care ..... 6
- PEerspective in Healthcare Real Estate ..... 7
- Getting AMPed up for Physician Compensation Models ..... 8
- Mark Your Calendar... ..... 9

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CONTINUED FROM PAGE 1

## BEHAVIORAL HEALTH

the many states where true behavioral health parity has been achieved.

Unfortunately, the reality of “parity” has been a mixed state-by-state patchwork of coverage (or lack thereof), which has resulted in an ongoing tussle between payers, treatment providers and regulators. Now New York State offers an intriguing model in which regulators are enforcing mental health parity laws as part of a proactive two-year campaign. Most recently, in March of 2015, New York State Attorney General Eric Schneiderman announced a settlement with Excellus BlueCross BlueShield, headquartered in Rochester, N.Y., after [alleging](#) that Excellus had violated the state and federal mental health parity laws by using inappropriate behavioral health reimbursement criteria.

According to the attorney general's investigation, Excellus required that members fail outpatient treatment multiple times before getting inpatient care. Such a protocol contradicts state law and is not applied by Excellus to medical care. Schneiderman alleged that some denials appeared arbitrary, and Excellus did not appropriately cover residential treatment for behavioral health conditions in its standard contract.

As a result, the nonprofit health insurer now must notify its 3,300 clients who were denied

inpatient behavioral health services of their right to appeal, cover the cost of the attorney general's \$500,000 investigation and may be required to reimburse approximately \$9 million.

This is an important moment in shaping the industry's trajectory, as Excellus is one of five major companies to recently reach such a settlement regarding violations of the MHPAEA. Previously, Schneiderman's office settled with [ValueOptions](#), [MVP Health Care](#), [EmblemHealth](#) and [Cigna](#) for parity violations.

With the aggressive enforcement of the federal MHPAEA mandate, the tide is continuing to shift toward greater coverage for patients with substance abuse and mental health issues in New York—which may now serve as a model for other states as they address issues of behavioral health and medical illness “parity.” This will provide an additional boost in behavioral health revenues, particularly for inpatient and substance abuse treatment centers. It will also set the stage for increased investment in behavioral health by healthcare investors, who will continue to see room for growth as reimbursed revenues increase.

Over the next five years, we envision more and more consolidations, mergers and acquisitions in this field as investors recognize the unique

## DID YOU KNOW...

According to a **Moody's Investor Service** report, 2014 operating margins for hospitals in Medicaid expanded states didn't increase any more than hospitals in the 22 states that have sat out the expansion.

Healthcare deal value reached \$97.9 billion in the first quarter of 2015, more than twice as high as Q1 2014's \$48.9 billion, says **Modern Healthcare's Q1 M&A Watch**.

**Avalere** estimates 73 percent of the more than 46 million Medicaid managed-care beneficiaries will receive services through managed-care plans by the end of this year.

The **2015 BDO Life Sciences RiskFactor Report** reveals 96 percent of life sciences companies cite concerns related to reimbursement changes and their availability, including payments from Medicare and Medicaid, up from 85 percent in 2014.

**Black Book's** latest survey finds 92 percent of providers looking for a revenue cycle or practice management upgrade are only targeting systems that revolve tightly around electronic health records.

A report from the **Ponemon Institute** finds data breaches in healthcare cost the industry about \$6 billion per year.

confluence of investment opportunities inherent in a market dominated by small niche behavioral health programs. As these programs join together, they will be able to create value for patients, communities and investors. The efficiencies created should result in improved care delivered by highly profitable, clinically excellent programs.

*This article first appeared on the [BDO Knows Healthcare blog](#).*

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# DS RIP IN NEW YORK: LEADING THE VALUE-BASED HEALTHCARE WORKFORCE STRATEGY EVOLUTION

By Patrick Pilch, CPA, MBA, The BDO Center for Healthcare Excellence & Innovation

## As the shift to value-based healthcare for Medicaid moves from hospital-centric to more community-based models, Medicaid patients will experience healthcare differently.

With fewer hospitalizations, the healthcare workforce will need to shift in support of the new model - including greater cultural literacy and the right cultural competency training designed to serve more diverse Medicaid populations.

While the "where" and "when" will be some of the most obvious changes to consumers, the "who," "what" and "how" pose some of the greatest challenges to those leading the healthcare paradigm shift from volume to value. Current models of waiting rooms, hierarchical physician-nurse-staff relationships and access to providers are rooted in 100+ years of care model history. Overcoming that inertia will require overhauling training programs, partnering with educators, defining new care provider roles and relationships, and planning staffing models and technologies for a value-based future that is not quite here yet.

The complexity of the endeavor is compounded by the fact that it's no longer possible to develop a workforce strategy in isolation. New collaborations and partnerships in pursuit of value-based care have, in theory, linked distinct workforces. The time has come to realize the promise of partnership by linking those workforces in practice.

Promoting community-level collaboration among care providers demands a sustainable care management model, which in turn requires 1) right-sizing staffing across the network, accountable care organization, Performing Provider System or other such integrated enterprise (henceforth referred to as the "network"), 2) training models that reflect new care flows and reimbursement paradigms, and 3) actionable patient data, workflow tools and analytics that enhance the productivity of care managers.

## RIGHT-SIZE THE CARE MODEL

It's tempting, in developing a cross-provider workforce strategy, to apply a member hospital's philosophy and training modules across a network to establish consistency. Shoe-horning 100-year-old staffing models into telemedicine, big data and population health, however, would be a great mistake that ignores the opportunity to entirely redefine care delivery protocols and structures for a very different future.

The future of healthcare demands shifting basic care, and even some moderate care, out of the hospital to outpatient settings. It demands training and deploying new community liaisons to coordinate the care of patients with chronic comorbid conditions. And it demands faster communication, greater accountability for outcomes and, therefore, better access to and application of analytics by care providers on the ground.

All this means that networks must evaluate where they stand on the journey to population health and what goals they want to meet, and then assess their cross-continuum workforce needs in the context of those goals. Through such workforce analysis, they may realize they need to redeploy physicians to community care locations, and that they require an incentive program to encourage voluntary relocation. They may discover a gap in communication between behavioral health providers and primary care physicians that coincides with medical noncompliance, and determine they need to create a new care coordinator role to liaise one-on-one with patients. They may also realize, through human resource assessments, dissatisfaction among nurses whose care protocols consistently result in back injuries.

## TRAIN THE TEAM

Providing care in an integrated setting demands more than just medical knowledge. Physicians must be encouraged to keep patients within the network and taught new tools, e.g., online referral programs, to do so. Nurses may be expected to formally take on

more complex care as basic-acuity patients shift to outpatient settings and as the network provides new interventions for patients with chronic conditions. Redefining "who does what," and then training for those roles across all roles and all settings, will be required to avoid both redundancy and care gaps.

The workforce strategy must differ for every network in order to account for cultural differences among physicians and staff and for population peculiarities. On Staten Island, for example, 40 percent of one defined population speaks English as a second language, if at all. To impact behavioral healthcare outcomes in that population by, for example, interrupting risky or unhealthy behaviors such as poor diet or drug abuse that complicate chronic conditions, the population needs culturally competent healthcare liaisons – yet another training component.

Collaboration among care providers and community stakeholders will be critical at every stage of population health management, but particularly at redesigning care and retraining the workforce. Engage the unions representing your workforce in designing and implementing new care management best practices, in soliciting input on employment wages and benefits and skill development, and in defining training requirements. Local nonprofits and advocacy groups may be able to help identify less-obvious cultural competency requirements. Schools, too, will play a major role in training and re-training the workforce, and new curricula may actually be required to develop newly created roles and to encourage career choices that support recruiting efforts.

## EMPOWER THE LEADERS

The goal of strategic workforce planning is to ensure that a network has the necessary talent to meet future staffing needs, which includes leaders at all levels along the continuum. Besides identifying initial training needs and talent gaps, workforce analyses can also pinpoint areas for future training opportunities, empowering and encouraging

CONTINUED FROM PAGE 3

## WORKFORCE STRATEGY

care providers at all levels and supporting their personal development as well as organizational growth.

Empowerment also comes through data, which must break the barriers of the finance departments and be accessible to providers on the ground. Care managers with access to actionable analytics will be better able to target the right patients, at the right time, in the right setting, and thus reduce the cost of care by providing the right care when it's needed.

Documenting this care, too, will be essential and will require additional training. Not only is it necessary for communication along the continuum and among providers caring for, e.g., patients with comorbid conditions, but it is increasingly the metric by which networks will be paid as reimbursement shifts from volume to value.

Integrated workforce strategy is a challenge that shouldn't be underestimated and that has dramatic implications to the overall cost of care and to the community's well-being.

Know when your network needs help at each stage – whether you are using analytics to identify variables in populations and cultural competencies required to address them, researching innovative models that incentivize voluntary staff redeployment, devising a comprehensive healthcare workforce or recruiting strategy, or training and integrating new types of care providers.

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# NEW PAYMENT MODELS BRING NEW HEALTHCARE DATA MEASUREMENT REQUIREMENTS

The BDO Center for Healthcare Excellence & Innovation and Rivkin Radler explore the rise of quality data as a reimbursement benchmark in this three-part series. Future newsletters will delve into the implications for measurement strategies and compliance.

By Geoffrey R. Kaiser, Esq.

Quality data is moving to the forefront of healthcare as a critical element of value and will serve as the basis for reimbursement made by government payers. This can be clearly seen in new population health management models for healthcare delivery, including Accountable Care Organizations (ACOs) and Delivery System Reform Incentive Payment (DSRIP) programs now being implemented across the country. Moreover, various government-sponsored initiatives will reward the quality, and not just the volume, of healthcare. This shift, in turn, places increased importance on measures to assess accurate measurement of quality reporting.

## REWARDING THE SHIFT FROM VOLUME TO VALUE

A principal method to improve quality outcomes and reduce healthcare costs involves changing the ways in which providers are paid to reward positive outcomes and coordinated care strategies, not service volume and its attendant inefficiencies. The government's goal is to have 30 percent of Medicare payments into alternative payment models as described in categories 3 and 4 of the chart on the next page by the end of 2016. By 2018, the aim is to have 50 percent in categories 3 and 4, and 90 percent of all fee-for-service payments in value-based purchasing models (categories 2, 3 and 4).

There are several models that align and incent quality and outcomes with reimbursement.

## EXAMPLES OF VALUE-BASED PAYMENT MODELS

**Accountable Care Organizations:** ACOs are voluntary groups of physicians, hospitals and other providers who coordinate their

services with the goal of improving care delivery for Medicare beneficiaries. When an ACO succeeds in delivering high-quality, cost-efficient care, it can share in the savings achieved for Medicare. Accordingly, the ACO model emphasizes accurate reporting of data related to quality. Performance benchmarks on quality are phased in over an ACO's second and third performance years. There are 33 quality measures, scored as 26 individual measures and 2 composite measures, with the 33 quality measures covering patient/caregiver experience, care coordination/patient safety, preventive health and at-risk populations.

### Delivery System Reform Incentive

**Payment:** The DSRIP program is another value-based healthcare model being used in some parts of the country. In New York State, the DSRIP program is intended to foster integrated, collaborative healthcare delivery and transformational system reforms with the goal of reducing avoidable hospital use by 25 percent over five years. DSRIP payments are rewarded based upon the achievement of DSRIP project milestones, supported with quality data reporting submitted to the New York Department of Health.

## EXAMPLES OF PROGRAM INITIATIVES THAT INCENT QUALITY

### Hospital Value-Based Purchasing Program:

Medicare payments for inpatient acute care are tied, in part, to the hospital's performance on certain quality measures in four domains: (1) clinical process of care; (2) patient experience of care; (3) outcome; and (4) efficiency. Medicare payments of participating hospitals are reduced by a certain percentage and then the total amount of those payment reductions are used to fund



CONTINUED FROM PAGE 4

**NEW PAYMENT MODELS**

Payment Taxonomy Frameworks and Their Relations to Quality				
	Category 1: Fee for Service – No Link to Quality	Category 2: Fee for Service – Link to Quality	Category 3: Alternative Payment Models Built on Fee for Service Architecture	Category 4: Population-Based Payment
DESCRIPTION	Payments are based on volume of services and not linked to quality or efficiency	At least a portion of payments are based on the quality or efficiency of health care delivery	Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or two-sided risk	Payment is not directly triggered by service delivery so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., one year).
MEDICARE FEE FOR SERVICE	<ul style="list-style-type: none"> <li>Limited in Medicare fee-for-service</li> <li>Majority of Medicare payments now are linked to quality</li> </ul>	<ul style="list-style-type: none"> <li>Hospital value-based purchasing</li> <li>Physician Value-Based Modifier</li> <li>Readmissions/Hospital Acquired Condition Reduction Program</li> </ul>	<ul style="list-style-type: none"> <li>Accountable care organizations</li> <li>Medical homes</li> <li>Bundled payments</li> <li>Comprehensive primary care initiative</li> <li>Comprehensive ESRD</li> <li>Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model</li> </ul>	<ul style="list-style-type: none"> <li>Eligible Pioneer accountable care organizations in years three to five</li> </ul>

Source: [Centers for Medicare & Medicaid Services](#)

value-based incentive payments to hospitals based on performance. For 2015, the Centers for Medicare & Medicaid Services (CMS) increased the portion of Medicare payments available to fund value-based incentives under the program from 1.25 percent to 1.50 percent of the base operating Diagnosis-Related Group payment amounts to all participating hospitals.

**Hospital Readmissions Reduction Program:**

This program encourages patient safety and care quality by reducing Medicare payments to hospitals with excess readmissions. The

readmissions measures used are endorsed by the National Quality Forum. For 2015, excess readmissions could result in a hospital's payments being reduced by up to 3 percent of base discharge amounts.

**Hospital-Acquired Condition Reduction Program:**

Under this program, hospitals that rank in the worst-performing quartile in respect to hospital-acquired conditions (HACs) receive lower Medicare reimbursements. The quality metrics used to evaluate hospitals are central-line-associated bloodstream infections, catheter-associated

urinary tract infections and the patient safety indicator 90 composite, a collection of eight quality measures including blood clots, pressure ulcers, hip fractures and infections. As reported in Kaiser Health News in December, CMS cut Medicare payments totaling approximately \$373 million, and 721 hospitals were impacted. This amounted to a 1 percent reduction over the course of the fiscal year ending in September 2015.

**End-Stage Renal Disease (ESRD) Quality Incentive Program:** This program also reduces Medicare payments should quality measures slip. The quality measures, which are counted for a half-million Medicare beneficiaries with ESRD, relate to anemia management, dialysis and iron management adequacy, bone mineral metabolism, vascular access, and patient satisfaction. Facilities can lose up to 2 percent of Medicare payments in the applicable payment year if their quality measurements are too low.

The evolution of the healthcare payment model from a fee-for-service system that rewards increased volume of patients, services and procedures to a quality-based system that rewards improved healthcare delivery and patient outcomes is profound in its implications. In subsequent articles, we will address how this change in healthcare reimbursement affects the ways in which providers need to address operational compliance around quality data reporting, as well as the compliance ramifications of quality reporting errors.

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# EVOLVING PORTFOLIO AND REAL ESTATE STRATEGIES IN U.S. HEALTHCARE SYSTEMS: THE RISE OF OUTPATIENT AND AMBULATORY CARE

By Patrick Pilch, CPA, MBA, and Rachel Lauren, The BDO Center for Healthcare Excellence & Innovation



**Earlier this year, Tenet, the \$16.6 billion Texas-based health system, announced two new deals that will make it the largest operator of ambulatory surgery providers in the country.**

The two deals are the capstone on a phenomenal 2014 for Tenet, which enjoyed its best annual earnings in the last decade, according to the company. Tenet has achieved strong results in part due to its thrust into outpatient and ambulatory care – a smart way of driving down real estate and facility costs while ramping up patient volume.

As aptly stated by Clint Hailey, Tenet's Senior Vice President and Chief Managed Care Officer, in *Healthcare Dive*: "The more outpatient you own as a percentage of your portfolio of assets, the lower cost profile you have."

Tenet is not alone. The move toward outpatient care has been a steady and clear shift in U.S. healthcare. In fact, today, outpatient services account for approximately 60 percent of all U.S. hospital revenues, compared to 10 percent to 15 percent in the early 1990s.<sup>1</sup>

## **TAILWINDS DRIVING THE RISE OF AMBULATORY AND OUTPATIENT CARE**

In the last four years, the number of stand-alone outpatient and ambulatory care clinics has risen dramatically as health systems across the country begin to align costs and services for patients and focus on margin drivers.

This shift is focused on moving relatively healthy patients – meaning Americans with non-emergent or non-acute conditions – from an inpatient/hospital setting to a lower-cost ambulatory setting.

Advances in health technology are accelerating the shift, allowing procedures previously conducted inside the four walls of the hospital facility to be conducted more cost-effectively in the ambulatory setting.

As a result, numerous physicians have begun to establish groups of their own capable of providing urgent care, diagnostic imaging and preadmission testing services in convenient and accessible settings for patients. From City MD to OrthoNow, new metropolitan stand-alone clinics have also taken hold.<sup>2</sup>

To counteract competitive ambulatory care facilities, hospitals and health systems are investing heavily in the development of their own ambulatory care and surgery models. New York Presbyterian Hospital, a Manhattan-based hospital with \$3.7 billion in annual revenue, is building a large-scale ambulatory facility with an expected total cost of close to \$1 billion.<sup>3</sup> The new facility will provide surgery, primary care and infusion therapy services, radiology and MRIs. In addition, the new facility is expected to offer comprehensive preventative and specialty services in an outpatient setting. Other health systems, like Tenet, are rapidly buying surgery centers given the high margins for such procedures. The transition can be perilous, as hospital processes considered efficient best practices in the inpatient setting do not necessarily translate seamlessly to ambulatory and outpatient care models and surgery centers, requiring re-examination of best practices in the new setting.

## **THE FUTURE EVOLUTION OF HEALTH SYSTEM PORTFOLIOS**

Moving forward, outpatient clinics and facilities will continue to increase as a percentage of U.S. health system portfolio

CONTINUED FROM PAGE 6

## EVOLVING PORTFOLIO AND REAL ESTATE STRATEGIES

assets. This offers opportunity for health systems and real estate investors.

Stand-alone rural or nonprofit hospitals – particularly those with higher portions of Medicaid patients – must analyze their portfolios of services sooner rather than later. Additional pressures to transform are arising from newly issued 1115 Medicaid Waivers designed to reduce avoidable hospitalizations and unnecessary ER visits by double-digit percentages. Analytics should inform local communities' health needs to eliminate duplicative services and help articulate the future-state model of care. The right portfolio mix of services, and asset strategies including real estate, optimizes the value of these high-cost and high-value assets. Hospitals may consider partnering with healthcare REITs or other private capital sources.<sup>4</sup>

Hospitals must consider how strategic M&A activity, physician engagement aligned with outcome-focused incentives and appropriate clinical alignment with larger systems will enhance their portfolios of services. The right M&A strategies will provide such hospitals access to the partners and capital they need to build their own ambulatory capabilities.

In summary, value will be created many ways in the transformational period of healthcare reform. Understanding the implications of synthesizing and aligning capital with outcomes-based reimbursement and delivery models, and with total cost of care, can create tremendous value for patients, investors, lenders and regulators.

*This article first appeared on the [BDO Knows Healthcare blog](#).*

1 [Modern Healthcare, August 2012](#)

2 [Crain's New York Business, March 2015](#)

3 [Crain's New York Business, March 2013](#)

4 [Wall Street Journal, March 2015](#)

*With acknowledgment to researcher Marcus Warmington.*

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## PErspective in HEALTHCARE REAL ESTATE



While the number of senior housing real estate deals continues to rise, [deal sizes seem](#)

[to be on the wane](#). In 2011, the 312 senior housing and care deals totaled \$27.6 billion in transaction volume, according to data from the National Investment Center for Seniors Housing and Care (NIC). By comparison, from the second quarter of 2014 to the first quarter of 2015, there were 609 deals totaling \$19.9 billion, according to NIC data.

Healthcare property investors—real estate investment trusts (REITs) and private equity firms—are especially attracted to the senior housing sector because of its market fundamentals. Aging demographics mean growing demand and, since most facilities are private-pay, they are less susceptible to government funding decisions than other healthcare properties such as hospitals and skilled nursing facilities.

Some larger REITs have been [concentrating their portfolios on the senior housing sector](#) to limit their exposure to government reimbursement issues. Healthcare REIT Ventas [announced in April](#) it would spin off most of its skilled nursing facility portfolio into an independently traded REIT. Meanwhile, Health Care REIT [raised \\$750 million](#) through a benchmark offering of senior unsecured notes to fund, among other things, investments in healthcare and senior housing products.

However, since large portfolio deals in the senior housing sector have been harder to come by recently, some large REITs are downsizing to move the needle with smaller portfolio and

single-asset acquisitions—and some industry insiders predict more REIT spinoffs could be on the horizon. These spinoffs make attractive targets for PE firms. For example, a number of PE firms are currently bidding for an operating company spun out of a [recent merger](#) between Ventas and hospital provider Ardent Health Services. The sale of the company [could fetch upward of \\$500 million](#).

Analysts have predicted that senior housing will go from a niche sector to a mainstream asset class during the next 15 years as the population ages. The sector is highly fragmented, meaning there are plenty of opportunities for consolidation as smaller providers look to achieve economies of scale.

Distressed deals present additional opportunities. Bankruptcies – as a result of market forces and healthcare reform – are on the rise in the senior housing sector. Mid-sized providers are looking to [grow by acquisition](#) after a period where they were priced out of such deals. Although far from straightforward, a successful makeover of a distressed senior housing property can make it an [attractive target for REITs](#) and PE firms further down the line.

Big portfolio deals may be down, but there are still plenty of investment opportunities in the senior housing sector as large players spin off businesses and small players look to consolidate.

*PErspective in Healthcare is a feature examining the role of private equity in the healthcare industry.*



# GETTING AMPed UP FOR PHYSICIAN COMPENSATION MODELS

Venson Wallin, CPA, and David Friend, MD, MBA, The BDO Center for Healthcare Excellence & Innovation

**The days of maximizing daily patient visits are waning, with the emphasis on visit quantity being replaced by quality – visits of value.**

As the drivers of healthcare reimbursement continue to refocus on new performance-based models, better clinical processes will, in general, mean higher reimbursement. Medicare and Medicaid have already incorporated improved clinical processes into determining provider reimbursements, with commercial insurers sure to follow.

The treating physician is a critical component of a successful clinical process. Over the years, however, physicians have had to focus on productivity as they've been expected to treat more and more patients daily with increasingly complex conditions. Some believe the constant chasing of productivity measures such as relative value units (RVUs) – a significant metric used in determining physician compensation – has led to a reduced focus on the quality and cost of patient care processes and outcomes. While steps are being taken nationally to address less-than-optimal clinical processes, it's time for health systems and physician groups to dial up the energy on incenting visits of value.

## EXPECTATIONS FOR PERFORMANCE FOCUS

The Affordable Care Act (ACA) attempts to incent value-based care with various initiatives, including programs that penalize readmissions and hospital-acquired conditions. It mandates that CMS use cost and quality data to adjust physician payments under the Medicare Physician Fee Schedule. Beginning in 2015, this Value-Based Payment Modifier will apply to physicians in groups of 100 or more; in 2016, it will impact physicians in groups of 10 or more; in 2017, all physicians participating in fee-for-service Medicare will be affected.



## PHYSICIAN COMPENSATION MODELS FOR IMPROVED CLINICAL PROCESSES

Some health systems are beginning to re-evaluate physician compensation models. In all likelihood, commercial payers will follow with value arrangements of their own. And the continued emergence of narrow networks and Accountable Care Organizations (ACOs) necessitates that practice groups analyze their compensation models in order to demonstrate high value in terms of clinical processes and outcomes. MGMA's *Physician Compensation and Production Survey: 2014 Report Based on 2013 Data* found that the percentage of compensation plans among participants based 100 percent on productivity has declined (39 percent in 2013 vs. 50 percent in 2012), and that the trend is expected to continue, with plans that combine salary and incentives gaining a greater share.

## GETTING "AMPED" UP: THREE GUIDING CONCEPTS

So what should hospitals and practice groups do to address the move to value-based compensation? Focus on three concepts: Autonomy, Mastery and Purpose.

- **Autonomy:** the freedom of a physician to make appropriate decisions for his or her patients
- **Mastery:** a physician's ability to achieve the highest level of professional training
- **Purpose:** a physician's access to the resources and opportunity to attain the best possible outcomes for his or her patients

These AMP concepts help transform physician compensation design from an "us vs. them" to a "we" approach. Using AMP, physicians, health systems and other network partners can work together to create a compensation



CONTINUED FROM PAGE 8

## PHYSICIAN COMPENSATION MODELS

model that successfully engages physicians while also meeting the shared goals of the other partners.

Once the AMP process has been agreed upon, the practice group/health system must identify the drivers that will lead to accomplishing its shared goals. It is important to remember that there is no “cookie cutter approach” to compensation model design. Rather, each model should be designed for its unique participants and goals. Collaboration and transparency are necessary to identify and implement the drivers that will most effect the desired change - and *only* drivers that directly result in the desired change should be included. Overloading the model with measures that are unrelated to inspiring change will increase the administrative tracking and reporting burden without demonstrating a return on investment.

Many physician compensation models utilize a combination of the following and other drivers:

- Medical assistance with tobacco use cessation
- Breast cancer screening
- Adult body mass index screening
- Patient panels
- Utilization of electronic medical record
- Gpro CMS measures
- HCAHPS scores
- HEDIS measures
- Readmission rates
- Utilization of clinical guidelines in evidence-based medicine and computerized physician order entry
- Patient satisfaction

When identifying your drivers, keep in mind that some drivers may promote the wrong behavior if not modeled correctly. For example, a driver regarding clinical guidelines should be flexible enough that physicians have the ability to prescribe clinically appropriate exceptions. Patient satisfaction drivers can also be mis-modeled. The fear of saying “no” to a patient’s request for a test or prescription may lead a physician to give the patient what he or she wants, even if it may not be medically necessary. They get a good mark on the patient satisfaction score, but incur avoidable care costs. Drivers can be strategically chosen to hedge against such

## MARK YOUR CALENDAR...

### JULY 2015

July 13-15

#### Healthcare Analytics Symposium

The Westin Chicago River North  
Chicago

July 20-21

#### Becker's Hospital Review Annual CIO/HIT + Revenue Cycle Summit

The Ritz Carlton Chicago  
Chicago

July 23-25

#### Health Forum and AHA's 23rd Annual Leadership Summit

San Francisco Marriott Marquis  
San Francisco

### AUGUST 2015

August 9-12

#### AHRMM15 Conference & Exhibition

Indiana Convention Center & Lucas Oil Stadium  
Indianapolis

August 19

#### AAHAM Western Region Educational Event\*

PIH Whittier Hospital  
Whittier, Calif.

\* Indicates that BDO representatives will be present at conference.

August 20

#### Modern Healthcare's Women Leaders in Healthcare Conference

Omni Hotel  
Nashville

August 23-25

#### NACHC 2015 Community Health Institute

Hyatt Regency Orlando  
Orlando

### SEPTEMBER 2015

September 13-15

#### 25th Annual SOCAL and San Diego-Imperial Chapters Fall Conference\*

Hyatt Regency Long Beach  
Long Beach, Calif.

September 28-October 1

#### Moments of Change\*

The Breakers  
Palm Beach, Fla.

September 30-October 2

#### 25th NIC National Conference\*

Gaylord National  
Washington, D.C.

behaviors. For example, combining patient satisfaction scores with other measures associated with clinical processes can somewhat lessen the impact of a negative patient satisfaction score. In the end, choose a combination of drivers that complement each other, promote efficient processes and positive outcomes, and minimize unnecessary costs of care.

Developing a successful physician compensation model can be accomplished in a minimally stressful manner by keeping it simple. Work together. Communicate. Be open and honest. Keep the end in mind (improved population health), and work to design a model that provides a clear path to achieving that goal while also remaining flexible enough

to maintain and improve efficiencies in the care delivery process. By following these simple rules, you can get your physicians “AMPed” up and drive success across the organization, be it a physician group, health system or ACO/narrow network.

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