CMS Attacks on CAH Status: What Colorado CAHs Need to Know

Colorado Rural Health Annual Conference

October 17, 2018
Colorado Springs, CO

Presented by
David H. Snow
• CAH Background & Location Limitations
  • 2013 and since – Breaking Bad
    – Challenges to CAH status
    – Recent victories and relief
• General CAH Review & Update
  • Bed size, DPUs, I/P Requirement
  • Reminder for CAHs with Multiple Providers
  • Off Campus Provider Based Limitations
• Provider Based RHCs
  • Best thing going
  • In your face on steroids....
• Affiliation? Joint Ventures? or else ........?
History of CAH Program

• After IPPS/DRGs in 1983- rash of rural hospital closures
• Demonstration project in Montana in late 1980s to pay rural hospitals based on cost
• CAH program introduced in 1997 to preserve access to primary/emergency services in rural communities
• Intended to be limited service hospitals providing essential services
• The number of CAHs grew faster and bigger than anticipated:
  – 41 in 1999 -> to 1,055 in 2005 -> to over 1,300 today
  – About 50% of rural hospitals, 22% of all, Average +$1m/CAH
  – About 850 are Necessary Providers
CAH Program

Location of Critical Access Hospitals
Information Gathered Through June 30, 2012

Legend
- Critical Access Hospital (1,327)
- Metropolitan County
- Nonmetropolitan County
- State Not Eligible or Not Participating


*Note: Core Based Statistical Areas are current as of the December 2009 update. Nonmetropolitan counties include micropolitan and counties outside of CBSAs. Produced by North Carolina Rural Health Research and Policy Analysis Center, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.
CAH Legal Basics

• 42 USC 1395x(e) (SSA 1861) Hospital ≠ CAH
  – The term “hospital” does not include, unless the context otherwise requires, a critical access hospital as defined in 1395x(mm)(1), which refers to....

• 1395i-4 (SSA 1820) Medicare rural hospital flexibility program

• CAH Conditions of Participation @ 42 CFR 485.600+ (NOT 482)
  – State Operations Manual on CMS's website/som107ap_w_cah.pdf
  – Interpretive Guidelines Appendix W
  – Not conditions of coverage/payment

• Provider Numbers = xx-13xx
  – Nomenclature for Provider & Supplier certification #s
CAH Legal Basics & Semantics

• **Licensure:**
  – State Law enforced by state department of health
  – Often simultaneously do Medicare COP survey

• **Certification/Conditions of Participation:**
  – Requirements to be paid for treating Medicare patients
  – There are non-Medicare participating hospitals

• **Accreditation:** Private organizations issuing approvals to their standards, for a fee by agreement
  – Deeming authority: TJC, HFAP, DNV
  – Accreditation approval = auto Medicare approval
CAH Location Requirements

• CAHs must be located:
  – In a rural county (non-MSA) or have a 412.103 deemed rural designation from CMS
  – >35 miles from a hospital unless:
    • Located in mountainous areas or have only secondary roads (15 miles) OR
    • Received state designation as a "necessary provider"

• States CANNOT issue new NP designations after 12/31/2005
  – Had to have NP designation, AND
  – Be certified as a CAH by January 1, 2006
  – to be grandfathered from 35 mile rule
Necessary Provider Status

- Administered by state offices of rural health
- State Plan established criteria used to determine NP status
- Common factors include:
  - Located in a HPSA
  - Demographic outlier criteria, such as:
    - County population > 65 is > state average
    - County Medicare &/or Medicaid > state average
    - County income %’s < state average
  - Some states required 1, others several, some varied based on distances to other facilities
- IF NP – find this info and keep for permanent files
2013 Was a Bad Year for CAHs

• 3/15/2013 CMS S&C 13-20 Revises CAH Survey Instructions
  – Reassess location tests on all full surveys
• 4/19/2013 CMS S&C 13-26-CAH issues new definition of mountainous terrain for 15 mile test
• August 2013 OIG Issues CAH Report
  – “Most CAHs Would Not Meet Location Requirements” (2/3rds)
  – Recommends
    • Remove necessary provider permanent exemption
    • Seek legislation to establish alternative location requirements
    • Periodically reassess location tests
    • Apply uniform definition of mountainous terrain
Reassessment of Location Test

• Pre 3/15/2013: Assessment of location test only made for initial application for CAH status

• S&C: 13-20 (3/15/2013) Revised SOM C-0160 to:
  – “Compliance with these location requirements must be reconfirmed at the time of every subsequent full survey. If a CAH moves, its eligibility for continued CAH status must be reassessed in accordance with § 485.610(d).”
  – Existing CAHs that are not grandfathered necessary provider CAHs must be periodically reassessed ... in the event that an existing CAH ... no longer meets the minimum distance requirement, ... it is provided the opportunity to avoid termination of provider agreement by converting to [PPS]”
New CMS Recertification Checklist

- Pub. 100-07 Transmittal 145 (8/21/2015) adds new Exhibit 356
- CAH Recertification Checklist for Surveyors, includes:
  - Rural status
  - Distance from other CAHs/Hospitals
  - Does 15 mile standard apply?
  - Necessary provider before 1/1/2006?
  - If not NP and does not meet the distance & location requirements:
    - enter into Regional Office tracking system
    - RO sends letter indicating CAH status will be terminated
    - Generally allowed 1 year to convert to PPS
But then it got worse…..

• 2015 Denial of CAH Applications (after initial approval) for:
  – Colorado Facility >35 miles, but other H PB’d site <35
  – Illinois Facility – Secondary Roads/nearest facility issue
• 2016 Denial of NY Applicant – Secondary Roads & MT issue
• 2017 Colorado CAHs
  – 2 “original” CAHs since late 1990s have to prove Rural status
  – CAH receives 90 day termination notice for comingling with SNF
• 2018 CAH Revocations for off campus sites:
  – Oregon CAH for <35 off campus site of another hospital
  – Washington CAH for its own off campus sites
Illinois & NY 15 mile Applicants

• Relevant Geography:
  – Nearest hospital/CAH >15 on secondary roads
  – 1 or more facilities <35 miles & NOT >15 secondary

• CMS practice is to measure to all or any other H/CAHs

• But - CMS Guidance and several ALJ decisions stated measure distance to nearest H/CAH not all
  – CMS uses nearest rule for sole community
  – Statute says >15/35 from a H/CAH, not all or any

• Facilities applied, were denied by CMS and appealed to ALJ
  – After briefs and >1 year wait ALJ upheld CMS denial
Co CAHs Required to Prove Rural

- 2017 CMS Regional Office Notified 2 CAHs – NOT rural
  - To be CAH, must be located in rural area or deemed rural
  - Both CAHs in urban/MSA counties
  - Approved as CAHs in 1999 and 2003
  - No 42 CFR 412.103 deemed rural approval on file
- Filed 412.103 Applications with RO based on meeting a rural area definition under state law
- CMS approved deemed rural and did NOT revoke CAH status
2018 Oregon CAH Revocation

• CAH Approved early 2000s, closest I/P campuses >40
  – Met necessary provider criteria but NOT approved as such
  – No need all I/P campuses >35 miles away

• 2008 CAH received approval for under development off campus PB’d based site 25 miles away & 25 from next hospital

• At some point hospital 50 miles away opened a PB’d site in same community – 25 miles from CAH

• Spring 2018 CMS issued CAH revocation because of:
  – CAH’s off campus site
  – Other hospital’s off campus O/P only PB’d site
2018 Oregon CAH Revocation

• CAH filed Reconsideration Request
  – Its own off campus site was approved by CMS & therefore GF’d
  – CAH could have been Necessary Provider if needed, so distance to other hospital HOPD irrelevant - obtained OORH confirmation that could have been NP & met criteria before 2006
  – Even if not NP, proper measurement is to I/P Campus not HOPD

• CMS agreed and rescinded CAH revocation
  – based on having met Necessary Provider status pre 2006
  – Did not address O/P only status of other hospital’s PB’d site
2018 Washington CAH Revocation

- CAH via Necessary Provider since circa 2003
- 2018 CAH Revocation Notice for 3 Off Campus Sites
  - PT/OT Center, Urgent Care & Specialty Clinic
  - 60 Days to Request Reconsideration o/w 1 year to revocation
- Specialty Clinic: Different street address but 150 feet from CAH Proper so on campus
- PT/OT in place since circa 1998, but:
  - Not added to 855A until 2016, No PB’d Attestation ever filed
  - Included as part of cost center – but not separately ID’d
  - Had real estate acquisition & construction form 1997
Washington CAH Revocation

- Urgent Care Site opened 2010
  - Approved by CMS for GF exception as under development before 1/1/2008
  - CAH had CMS correspondence approving site
- CAH Filed Reconsideration with documentation
- CMS rescinded revocation – accepted:
  - Google maps for Specialty Clinic location
  - PT/OT site acquisition documents and CAH assertion as to PB’d
  - CMS’ own paperwork for Urgent Care site!
Colorado Hospital Applied 2015

• Closest I/P Campus 38 miles away

• CRHC/ORH, Co DOH, CMS Regional Office All Said Eligible for CAH Location Test – NO ISSUES

• Hospital applied for TJC CAH Survey & PASSED 10/31/2015
  – Filed 855A and all paperwork for CAH
  – CMS National Office DENIED
    • Based on closest I/P hospital’s provider based site - only 32 miles away
    • Licensed by CDPHE as CCEC, with 3 “beds” (Observation, not I/P)
  – DESPITE CMS Manual Guidance – “measure to main campus”
Colorado Hospital Appeal Process

• Spring 2016 filed Reconsideration Request with CMS
  – CMS Manual Guidance says measure to MAIN campus of other hospital/CAHS
  – Statute says distance to other “hospitals” part of definition is licensed by state and I/P beds
  – CMS DENIED Reconsideration

• Summer 2016 Filed appeal with DAB/ALJ
  – Fully briefed by Fall 2016
  – Sat and waited for ALJ Decision

• Meanwhile hospital operates and bills as PPS/DRG/SCH
Colorado Hospital – In Limbo

- Conversion terminates old PPS CCN and receive new CAH CCN
  - Usually hold billing pending CAH Tie In Notice assigning new #
  - 12 Months from DOS to Submit Claims
  - Once Reconsideration Denied started billing in 3rd Quarter 2016

- Cost Reports Due Dates came and went
  - 6/30/16 & 2017 Filed Under Old PPS CCN

- Spring 2018 – The Joint Commission
  - Coming up on 3 year renewal survey cycle
  - CMS told TJC it could NOT do a CAH survey, only PPS
  - Working on Mock Survey to avoid gap in CAH COPs, WHEN.....
Colorado Hospital - VICTORY

• June 29, 2018 – CMS Open Door Forum – David Wright S&C
  – Addresses CAH Location Test, says CMS Regional Offices may have taken incorrect positions - measure only to I/P campus

• July 2018 CMS Attorney contacts counsel – CMS wrong
  – Hospital wins & gets CAH Status
  – Retroactive to 11/1/2015 !!!  30+ months

• NO ONE PERSON at CMS Understands Implications
  – Not Attorney, Regional Office, National Office...
  – And even if they did - no one has authority to fix in rational way
  – FI/MAC says w/o CMS direction, must rebill all claims...
Colorado Hospital – Cleanup

• Differences from PPS to CAH
  – Medicare O/P copay 20% charges not 20% fee schedule
  – Hospital instructed not to rebill that difference to patients
  – Lab & PT/OT/ST go on PS&R at fee schedule, not charges
  – No PS&R under new CAH CCN

• Now working with CMS & FI/MAC to avoid rebilling under CAH
  P# for last 30 months....
  – Instead, settle based on aggregate cost report basis, refiling:
  – 10/31/15 - 4 month final PPS CR
  – 6/30/16 - 8 month first as CAH, 6/30/17 12 month as CAH
  – Affects 340B, State Medicaid, etc....
Takeaways for CAHs

• CMS position that other hospital PB’d HOPD sites within 15/35 can jeopardize CAH status appears DEAD

• Necessary Provider CAHs
  – Likely no threat from distance to other H/CAH sites
  – or their off campus PB’d sites, if CMS changes back

• Find and maintain:
  – Original CAH and NP applications & approvals
  – Documentation of GF status of off campus sites
  – 412.103 Deemed rural approval if applicable

• If not a NP CAH, but could have been – document that!
CAH Size Requirements

• CAHs may operate up to 25 inpatient beds in any combination of acute care and swing beds

• CAHs may also have distinct part units in addition to 25:
  – Psych unit of up to 10 beds
  – Rehab unit of up to 10 beds

• Acute care must have ALOS <4
  – Over course of year – ALL patients not just Medicare
  – Exclude DPUs and observation – acute I/P
So what is a Bed?

- Counts toward 25 (Transmittal 138 SOM App. W, C-2011, 4/7/2015)
  - Use for I/P services at any time
  - Hospice under arrangement beds

- Do NOT count toward 25
  - Used solely for observation per clinical criteria
  - Stretchers, exam/procedure tables & OR tables
  - Sole use as surgical recovery room
  - Sole use for OB delivery/recovery & well baby bassinets
  - Beds in excluded rehab/psych units
Excluded Units

- CAHs can have up to 10 bed psych &/or rehab
- Paid under psych or rehab PPS – NOT cost
- Process for exclusion
  - Can only be excluded on 1st day of cost reporting period
  - Surveys cannot be retroactive to before date of survey
  - Catch 22 - cannot get survey until operational
  - Need to use some of 25 beds for "unit" pre-exclusion to trigger survey
  - Need lots of advance planning/notice to DHFS and CMS
Hospital Definition Update from CMS

• Primarily Engaged in Providing Inpatient Services
  – S&C Memo: 17-44 9/6/2017
  – SOM A-0022 § 482.1

• Primarily Engaged
  – State license as a hospital is necessary, but NOT sufficient
  – Capacity/potential to provide I/P is NOT sufficient
  – Acute care medical necessity, expecting 2 midnight stay
  – For survey must have 2 or more I/Ps = starting point only

• N/A to CAHs and PPS Excluded Psych Hospitals
CMS I/P Requirement for CAHs

• 42 CFR 485.635 – Patient Services
• State Operations Manual – Appendix W C-0281
  – Updated 4-7-2015: CAH furnishes acute care I/P services
  – Factors to assess
    • volume of ER services
    • Number of certified I/P beds
    • Dedicated observation beds? Ratio to acute care I/P beds?
    • Average occupancy rate & volume of admissions
    • Volume of observation patients
    • % of ED visits admitted to CAH vs. transferred
    • Range complexity & volume of O/P services
Hospital COP Governing Body

• 42 CFR 482.12 SOM Appendix A A-0043
• If part of “system” that includes separately certified hospitals (or other providers) – can choose governance/corporate structure:
  – Separate legal entity/board for each provider, or
  – all (CAH, SNF, HHA, RHC, etc.) in one legal entity
• But each provider must be able to independently demonstrate its compliance with the COPs – independent of any other facility. There is no survey of a “system” or a corporation.
Independent Demonstration of COPs

• May adopt identical policies & procedures, BUT documentation must be clear how they apply to specifically named hospital/provider

• Governing body policies & procedures must be presented that clearly apply to each hospital/provider
  – “System/legal entity has adopted the following policy” is not acceptable. Must state [H/CAH/SNF] has adopted
  – Minutes of governing body must be clear which provider actions apply to
  – Departments of separate providers cannot be operationally integrated
Independent Demonstration of COPs

• Policies & procedures for nursing services may be identical for each provider, but must operate separately
• Same person could be Director of Nursing for multiple providers, so long as able to carry out all duties, but must be clearly identified separate “chain of command” for each
• Nurse may work in multiple providers, but must have separate work schedules for each provider
• Likewise quality process and indicators may be identical but must be separately tracked by each provider.
CAH Provider Based Limit

• Final 2008 HOPPS rule – 11/27/07:
  – Any off campus location opened or acquired after 1/1/08 that meets provider based requirements must be >35(15 in M/SR areas) mile drive from any other hospital or CAH
  – Applies to excluded psych and rehab units also
• Essentially includes all PB’d sites in determining whether 35/15 mile/NP Location Rules Met
• Failure to comply: CAH status subject to termination unless the CAH terminates the off campus arrangement
  – Converting to free-standing should be sufficient
  – Not closing site
CAH Provider Based Limit

• Sites operated and qualified as provider based before 1/1/08 are grandfathered
  – “created or acquired after 1/1/08”
  – Converting free standing pre 1/1/08 site to PB’d after 1/1/08 is not grandfathered
  – CMS approval/attestation not required

• Relocation of pre-1/1/08 PB’d site loses grandfather status - it is site specific!!
  – May be outside CAH's control - lease termination

• Changes at grandfathered site:
  – Addition of footprint or services
  – Construction of new building to replace old
  – Should be able to keep status – but confirm with regional office
CAH Provider Based Limit

- After 12/31/2007 - CAH corporation is NOT prohibited from:
  - Operating free standing sites, just PB’d. So lose option to get:
    - Cost on hospital o/p facility services
    - 15% bonus for Method II professional billing
  - Opening Hospital Based - Rural Health Clinics
    - Exempt because not part of hospital provider
    - Have separate provider number
    - Subject to their own RHC COPs
CAH Provider Based Limit

- CMS Guidance 12/21/08 and 6/12/09
  - CAHs seeking a PB'd determination for newly created or acquired off campus sites **MUST** submit an attestation to Regional Office to determine location requirements
  - Regulation 413.65 says PB'd Attestations Optional
  - Follow Guidance
  - PB'd site may meet tests even though campus does not
  - And, remember 15 mile rule
Off Campus Clinic Location Example

(CAH-NP)

Primary Roads

Secondary Roads
Provider Based RHCs

• “Provider Based Entity” – not a hospital O/P department
  – Separate provider number
  – Subject to separate RHC CoPs
  – Exempt from some PB’d requirements, including:
    • License
    • Distance (w/i 35 miles of hospital to which it is based)
    • Public awareness
    • Off campus notice of split billing
    • Don’t count as a CAH off campus site for CAH location test
RHC Conditions of Participation

- RHC COPs at 42 CFR 491
  - Surveyed & certified like other providers
  - Location & facility requirements
  - Organization & staffing requirements
  - Services and medical record requirements

- Staffing
  - Midlevel on site 50% of time operated
  - At least 1 employed Midlevel (statutory requirement)
  - Other midlevels can be contracted for
  - Physician on site depending on facility/patient needs
    - once every 2 weeks eliminated May 2014)
Provider Based RHCs

• Not all services covered/billable under RHC provider number
  – Effectively only physician & midlevel office visits
  – Non-RHC covered services (ancillaries) must be billed separately:
    • Hospital/CAH provider # if PB’d
    • Physician office # if free standing
• CMS Position – non-RHC services @ RHC site do NOT trigger application of CAH location test
• RHC Mixed Use/Commingling
  – Benefit Policy Manual Chapter 13 § 100
  – May share facility and/or staff with FS’g clinic, HOPD, etc.
    • Waiting room, receptionist, etc.
    • Must allocate costs properly to RHC
PB’d RHCs Best Thing Going…

• Exempt from CAH Off Campus Location Test
  – Even if do non-RHC services billed under CAH CCN
• Exempt from some normal PB’d requirements:
  – Public awareness
  – within 35 miles of CAH to which it is based
• Still eligible for 340B Child Site status
• Cost reimbursement for E&M services, includes physician & midlevel compensation
  – Typically see cost/visit in $150-300 range
• Medicaid pays better
PB’d RHC In Your Face Example

• Region 8 (Not CO) Necessary Provider CAH #1
  – Acquires FS’g RHC in town 25 miles away
  – Across the street (<600 feet) from CAH #2 in that town

• CAH #1 plans to:
  – Convert RHC form FS’g to PB’d
  – Add non-RHC services to be billed under CAH #1 CCN – PT, Imaging, Lab

• Region 8 Approves
  – Because RHC/PBE does not trigger CAH off campus location test
  – Addition of non-RHC services billed as CAH O/P OK too
PB’d RHC On Steroids (& IYF)

- Region 5 (Chicago) CAH – also NP
- Opens PB’d RHC in town 20 miles away & 1 mile from PPS Hospital services to include:
  - Medical Oncology & Infusion
  - Imaging to include CT
  - PT/OT/ST
  - Maybe Rad Onc (Lin Acc) down the road....
- Region 5 Approved – No Impact on CAH status
Overview: Rural Hospital Predicament

- 2,322 rural hospitals in US
- 56 rural hospitals have closed since 2010
  - From 1983 to 1998, 440 rural hospitals have closed
- Currently, 283 rural hospitals are in danger of closing
- Rural hospitals - average of 50 beds/hospital; compared to 234 at urban hospitals
- Rural hospitals - 7 inpatients/day served on average, compared to 102 at urban hospitals

Pew Charitable Trusts, August 17, 2015
Overview: Perceptions can include…

• feeling like this kayaker

• and looking for the end of the rainbow

• The reality is more like this…
  – Local hospital leadership
  – System leadership and operational resources
  – Community buy in & support

• IF, done by choice, rather than when you have to…
A Game Plan to Respond

• Consider ALTERNATIVE Structures
  – Background on Corporate Governance
  – Review Various Affiliation Models
• Identify GOALS & OBJECTIVES
• Assess Relative BARGAINING POWER
• Determine the STRUCTURE to Achieve Goals
• Identify Legal CONSTRAINTS & ISSUES
• Establish a PROCEDURE to Move Forward
• Case Studies:
  – Special Contractual Interest Affiliation
  – Service Line Virtual Joint Venture
Corporate Governance & Control - Basics

• Non-Profit Health Systems
  – Typically use multi-corporate structures
  – Separate corporations for each provider/site
  – Use sole corporate member with reserve powers
  – Creates a wholly owned subsidiary effect

• Can use multiple members for shared control
  – Allow majority vote for some actions
  – Require unanimous vote for others
Affiliation Alternatives

• Non-stock corporate law concepts:
  – Member(s) & reserve powers
  – Super/special majority vote of directors
  – 3rd person rights

• Contractual arrangements
  – Management agreements
  – Joint operating agreements
  – Member agreements

• Infinite possibilities can be created
• No set recipes – no two affiliations the same
• There is a continuum of possible structures
Continuum of Affiliation Arrangements

Less Integration

- Management Agreement
  - Access to a “System”
  - Management services

- Joint Operating Agreement
  - Limited term
  - Preserve ownership of assets
  - Income sharing

Dual Member Corporation

- Create New Corporation to be a Member in CMH
- Local governance role retained

More Integration

- Merger/Sale of Assets – Full Integration
  - Permanent structural change with no termination “trigger”
  - CMH retains no reserve power

- Single Member Corporation
  - Effectively complete integration
  - May be able to negotiate termination “triggers” which return control to community and
  - Some local Board Member requirements
Identify Goals & Objectives

• Organizational survival
• Maintain or increase local level of care
• Maintain or increase services available
• Employee protection
• Quality improvement
• Tertiary affiliate(s)

• Enhanced technology and information systems
• Preserve local influence and control
• Capital contribution - Access to capital
• Prestige
• Others?
Assess Relative Bargaining Power

- CMH
  - Financial health
  - Market location
  - CAH status
  - ???

- Health System
  - $$$ & size
  - Efficiency of scale
  - Physician presence in market
  - ???
Determine Structure to Achieve Goals & Objectives

- Desired Local Input or Control
- Local Input or Control on:
  - Services offered
  - Management
  - Assets
  - Affiliations
  - Closure
- Permanent or sunset/unwinding
- Reversion rights
Potential Legal Constraints

• Bond Financing Restrictions
• Current Contractual Relationships
• Corporate Document Restrictions
• Regulatory Issues: Licensure, Tax, Medicare/Medicaid, Antitrust, Etc.
• Hospital/Health District Status
Hospital Districts – Extra Hurdle

• Create Newco nonprofit corporation under state law
  – Newco will enter into system affiliation arrangements
  – District will have governance rights per negotiated affiliation – including any unwinding rights
  – Generally: should be able to use any of models described

• Asset/Operations Transfer Agreement
  – Transfers District’s hospital (and other? – clinic) operations to Newco (including all assets except real estate)
Hospital Districts – Extra Hurdle

- **Real Estate Lease Agreement**
  - Hospital District leases real estate (and major equipment?) to Newco
  - District provides subsidy to Newco in accordance with mill levy
  - Newco uses real estate in accordance with District’s Service Plan
  - Lease is additional mechanism for District input & unwinding rights

- **Staff Services Agreement**
  - District could retain employment of some or all of Hospital staff
  - Lease or contract those employee services to Newco
Hospital Districts – Extra Hurdle

NEWCO (NFP Corporation)
- Hospital SNF, etc.
- Other: Clinic, etc.

Health Care System

Hospital/Health District
- Asset/Operations Transfer Agreement
- Real Estate Lease Agreement
- Staff Services Agreement?
Procedure

• Board/Leadership Education on Options
• Establish Authority to Proceed
• Identify Participants (RFP process?)
• Establish Timelines
• Identify and Resolve Operational Issues
• Due Diligence
• Develop Definitive Agreements
• Ensure Legal Compliance
• Closing
Case Studies: Proof of Infinite Options: Case Studies

• “Special Contractual Interest” Model
  – Effective partnership of local entity/operations
  – System investment in return for:
    • Shared capital & governance
    – Without cause unwinding back to status quo
• Not ready for the whole enchilada?
  – Consider Service Line Virtual Joint Venture
  – Shared capital, P&L, governance & management
  – But only for 1 or more service lines
Special Contractual Interest Example

CMH received:
- $5,000,000
  - $3.5 up front, some in kind via Epic access
  - $1.5 within 2 years
  - Restricted use: Epic & renovation per strategic plan
- Equated with 24% of total FMV
- 2 nonvoting reps on System board

Health System received:
- 2 of 9 Board seats
- Special Contractual Interest
  - Economic right to 24% of then FMV @ unwinding
  - Veto rights over CMH actions
  - System medical group preferred providers
Special Contractual Interest
Example

1. Gave CMH rights to approve certain actions.

CMH, Inc. \(\xrightarrow{\text{Special Contract Interest}}\) Local Hospital or Division

CMH, Inc. \(\xrightarrow{\text{Appoint “H Class”}}\) System Board (Parent Co.)

System Board \(\xrightarrow{\text{Local Board}}\) Local Hospital or Division

Board
Special Contractual Interest Example

- Actions requiring Health System Approval (via SCI – 3rd party rights)
  - Debt >$1m, or collectively $1.5m in 12 months
  - Amendments of Articles or Bylaws affecting Health System rights
  - Act or omission ending CAH status
  - Creation, transfer or dissolution of any CMH subsidiary
  - Acquisition of physician practice or service line
  - Merger, sale of substantially all assets, or dissolution
  - Sale or long term lease of any part of campus
  - Any service K with Competitive HC Organization
Special Contractual Interest Example

- **Term & termination**
  - 7 year initial term, with 1 year without cause advance notice
  - 5 year renewal terms
  - Cause termination = loss of 501(c)(3), bankruptcy, material breach

- **Effect of Termination**
  - CMH buys back “SCI” @ 24% then FMV
  - 10% down, 90% over 5 years with market interest rate
  - Health System governance rights in CMH cease
Virtual Joint Venture

Hospital 1

Cancer Services

Virtual Joint Venture

Medicare

UB-04 (TC&PC)

Other Payors

1500/UB-04 PC/TC

System or Hospital 2

Cancer Services Program Agreement

Professional Services Agreement Management / Admin Services Agreement
Comments on Virtual Joint Venture

- Allows for joint operation of service line (e.g., cancer services)
- Services provided and paid for through VJV, but billed by Hospital 1 (provider based reasons)
- Professional Services Agreement/Administrative and Management Agreement- Hospital 2 may provide physicians and administrative and direct patient care staff to Hospital 1
- Cancer services operated PB to Hospital 1
- VJV- same economic effects, but minimizes complexities compared to using a separate legal entity
- Currently working on a Master VJV – built to add service lines over time
- May be a starting point for more complete affiliation
Please visit the Hall Render Blog at http://blogs.hallrender.com for more information on topics related to health care law.

David H. Snow
dsnow@hallrender.com
111 East Kilbourn Avenue, Suite 1300 | Milwaukee, WI 53202
Direct: (414) 721-0447 | Main: (414) 721-0442

This presentation is solely for educational purposes and the matters presented herein do not constitute legal advice with respect to your particular situation.