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Post-Pandemic Crisis Affiliation: What is the New Normal?

Max Reiboldt, CPA, *President & CEO* | Coker Group
mreiboldt@cokergroup.com

Introduction

The COVID-19 pandemic has shaken the world and turned healthcare upside-down. In the United States and around the globe, the industry will never be the same. From A to Z, every entity will assess how they work. They will modify their processes accordingly, especially in light of the rapid adoption of telehealth as a viable alternative to a significant portion of in-office patient-physician provider visits. The transition is breath-taking, considering that in April 2020, over 43% of all Medicare primary care visits were done by telehealth compared to less than 0.1% in February. Further, currently and in the future, there will be more focus on remote monitoring as an alternative to inpatient observation.

In response to the dramatic change in healthcare delivery, on August 3, 2020, President Trump signed an executive order to make permanent the temporary flexibilities for telehealth allowed during the COVID-19 pandemic that was implemented in late March. The president announced that Medicare reimbursements would include telehealth visits at no additional cost, and copayments can be waived for telehealth services. The order will allow Medicare to cover more than 135 services through telehealth, including physical therapy, emergency department visits, home visits, mental health counseling, substance abuse treatment, pediatrics, critical care, and more. He went on to say that an estimated \$2 billion of additional funding will support the ability of Medicare patients to receive telehealth.¹

Revenue lost by hospitals and physician clinics through shutdowns and periods of sheltering in place at the outset of the pandemic disrupted budgets and forecasts based on patient volumes for 2020 and 2021. Although clinics are open and hospitals have resumed elective surgeries and other services, financial planning is difficult, not knowing how long the pandemic and its effect will last. Will patient behavior change, and to what degree, about patient office visits and elective surgeries? Also, more challenges surfaced in completing affiliation transactions, even though many believe that consolidation is essential. The future will tell.

Emphasizing Rural Healthcare

A concerted effort is underway to address the difficulties of attaining access to care in rural markets. Recent years have presented challenges for rural hospitals. Factors such as low reimbursement rates,

increased regulation, reduced patient volumes, and uncompensated care have caused many rural hospitals to struggle financially. Consequently, rural hospitals have adapted by modifying their services and structure, but many have closed. The providers in the healthcare industry have wanted the federal government to make telemedicine permanent. President Trump's executive order to make reimbursement changes permanent will satisfy that need. New policies for the use of telehealth beyond the pandemic will include the testing of payment models that empower rural hospitals to transform healthcare in their communities on a broader scale.

Technology advancements have the potential to increase access to and the quality of healthcare services in rural communities. Two examples include telehealth services and health information technology (HIT). They have advanced communication between physicians and patients and offer innovative methods of overcoming challenges of providing healthcare services to rural communities.²

The economic and transactional sides of the U.S. healthcare system will likely change as well, both temporarily and permanently. As consolidation continues, the more (and tighter) government regulations will create challenges that do not always correspond to other departments of government and their efforts to accommodate new forms and structures of healthcare providers.

Opportunities for Affiliation and Consolidation

After the pandemic subsides, it is uncertain whether healthcare providers will have a desire for further affiliation or consolidation. Prior to COVID-19, affiliation transactions were plentiful, as were the varied structures used to establish the agreements. Other elements where numerous transactions were occurring included the following:

- » A growing interest in privatization and maintaining a private structure
- » An increase in popularity in private equity investments, especially for larger groups and certain specialties
- » Hospitals and physician groups consortiums, such as clinically integrated networks
- » Competitive service offerings and collaborations like ambulatory surgery centers

The onset of the COVID-19 pandemic brought most discussions and potential transactions to a standstill because no one knew what to expect, and the economic constraints became serious almost immediately. For example, venture capital firms hesitated to move ahead because they did not know how their historical investments would react to the pandemic crisis, especially considering the significant reduction in workforce and lost productivity, or what benefits new investments would yield. The majority of new deals were halted temporarily and have yet to resume at their former level, although some signs of increased activity now exist.

Hospitals and physician groups will undoubtedly continue to consider transactional opportunities. However, with many employed or contracted physicians placed on furlough or working at a reduced salary, some may be reluctant to continue affiliating with hospitals. Those hospitals that ceased elective surgeries and other elective procedures to focus on COVID-19 patients have experienced enormous financial drains on their cash reserves. Post-pandemic, the immediate economic improvement in their bottom-lines is uncertain.

It is safe to say, therefore, that providers, investors, and especially the American consumer, have suffered significantly through the COVID-19 pandemic. As we begin to plow our way out of this crisis, we ask, “What is the new normal?” What will be the strategies for affiliation among the players as we emerge from the pandemic? What will be the same, and what will be different? This article will consider and discuss affiliation strategies and strategic planning for future transactions.

Overview of a Pandemic Crisis and the Characteristics of U.S. Healthcare

The pandemic’s persistence is creating serious challenges for the healthcare system, many of them unforeseen. Even before COVID-19, many hospitals were in precarious financial condition. The American Hospital Association estimates that altogether, U.S. hospitals are bleeding fifty billion dollars a month during the pandemic. The hundreds of thousands of doctors in independent practice have more limited capital reserves, and many may be forced to shutter their operations or merge them with others.³

Physicians’ attitudes toward rendering care have also been affected—not just by telehealth, but the overall premise of how best to deliver care to patients. For example, surgeons and other proceduralists who had their elective work curtailed have gone through an unprecedented period of lost income. They are understandably concerned about the next pandemic or other crisis that could cause another significant reduction in their earnings. In comparison to other industries, physicians have a shorter career span. If earning capacity is constrained during that career span, concern about future earning ability may be heightened. Therefore, physicians’ attitudes toward affiliation and consolidation will acquire an even greater emphasis post-pandemic. What are their options?

- » Hospitals have also experienced significant financial drains because of the COVID-19 pandemic. Many rural hospitals are “hanging by a thread.” Will these facilities survive, and if they do, what will their attitudes be toward provider employment? With limited resources and more challenges ahead post-

COVID-19 pandemic, we must navigate carefully through these options for hospitals while being fiscally prudent.

- » Independent or clustered investors, such as private equity and venture capital, must likewise revisit their strategies for investing in healthcare. In comparison to other industries, healthcare is still a solid prospect. And while the COVID-19 pandemic will change the paradigm of care, care providers will be essential. Given the fiscal limitations of hospitals and physicians, independent investor groups, e.g., private equity, could comprise a much higher percentage of the total affiliation model participant.
- » Finally, patients and the general population in the U.S. must adjust to these changes. They must realize that healthcare providers, while human, have a career to consider. Providers must build their own business and professional structures to respond to the country’s overall healthcare delivery system and the related fiscal requirements. Consumers, therefore, must become accustomed to increased consolidation in one form or another.

In the remaining sections, we delve deeper into alignment and related affiliation perspectives based on the COVID-19 pandemic and its effects. These include:

- » Physician-Hospital Alignment
- » Physician-to-Physician Affiliation
- » Physician-Investor Affiliation
- » Valuation and Compensation Ramifications

While no one has all the answers, we are all engaged in this transition together.

Physician–Hospital Alignment

Will there be a post-pandemic rush of physicians affiliating and aligning with hospitals? While the answer is uncertain, physicians across various specialties will undoubtedly have an interest in alignment. The impetus exists for working together and creating greater affiliation structures. Whether employment, professional services agreements (PSAs), clinically integrated network (CIN) affiliation, or other less integrated forms of “full” alignment, the post-pandemic interest in such models will occur.

Will hospitals be equipped to complete such deals? While most transactions may entail relatively little up-front money and capital, the attention of hospital leadership teams may be diverted post-COVID-19 pandemic as they focus on servicing patients on a “normal” basis—meaning, structuring elective surgeries and other typical areas of care will be a priority and will require capital that might have otherwise been dedicated to alignment transactions.

Physicians will be seeking further assistance. Many physicians will decide that they cannot remain independent and must have a partner. That partner will more than likely be hospitals and health systems as they seek protection, not only for COVID-19 recovery but from future crises.

Assuming a groundswell of interest among physicians for hospital affiliation, how will these transactions be formulated? As stated, these transactions may now involve relatively little upfront money. One notable exception is a “private equity-like” structure where earnings are created through a physician compensation reduction and value placed up front. These deals will continue to involve relatively little, if any, dollars associated with the purchase.

Compensation, which has sometimes been a source of improvement when physicians become employed or contracted by hospitals, may not be as robust under post-COVID-19 pandemic transaction structures. Hospitals can afford less as a result of the 2020 COVID-19 pandemic, which means compensation may be lower, or greater portions of compensation will be held at risk based on performance. Finally, future benchmark metrics may reflect lower compensation; specifically, surveys published in 2020 (based on 2019 data), may reflect lower than usual production and compensation standards. Compensation models tied to these benchmarks would be impacted. These dynamics could contribute to fewer alignment transactions.

Hospital-based specialties, e.g., hospitalists and inpatient physicians, radiologists, anesthesiologists, pathologists, and emergency medicine physicians, will still be in demand post-crisis. Before the crisis, many of their arrangements were PSAs and subject to extra support payments. These arrangements, or the level of financial support within them, may become more limited due to the financial stress on hospitals, post-COVID-19 pandemic. In the alternative, these arrangements may be converted to employment structures that have more fixed compensation (and thus, less variability in their payments and which will be easier to budget).

Hospitals will continue to have demand for physicians and perhaps, in some ways, more than ever. However, the transactions may look different due to the economic issues, in addition to the ever-growing presence of telemedicine. Telehealth services will be a major part of alignment and affiliation transactions, clinical delivery structures, and overall economic outcomes. While telehealth services are being recognized with improved reimbursement by both commercial payers and the federal government, there are still unanswered questions about how this productivity will be converted to physician compensation.

Thus, the following key characteristics will emerge post-pandemic:

1. Physicians will have an enhanced level of interest in affiliation and alignment.
2. The interest from hospitals will be more selective, and the compensation they offer to physicians may potentially be less lucrative (in economic terms). In the alternative, contract structures may change, putting a greater portion of compensation to the provider at risk by, for example, basing it on production and clinical outcomes.
3. Hospitals will be able to select from those physician groups they believe are most strategically, tactically, and clinically proficient. This factor will depend on the overall supply within their service area.
4. While the interest in alignment transactions will increase, transactions may not happen quickly, given the priorities of hospitals and health systems, as well as private practicing physicians to return to their normal progression and volume of services.

5. Telehealth will be an increasing factor of transactions going forward. This will include its ability to impact quality of care and value-based reimbursement.

Physician-to-Physician Affiliation

Will there be more group mergers after the pandemic wanes? The answer is likely “yes,” especially if hospitals are slow to respond to physician groups that still need a level of affiliation and collaboration with other providers. Group mergers of single specialties are usually easier to form. Multispecialty group mergers are more challenging and cumbersome, involving issues such as an appropriate income distribution plan (IDP). They often require an extended period to complete. Therefore, the first wave of mergers will probably be single-specialty group mergers. These affiliations could be under the banner of a clinically integrated organization (CIO) or other loosely formed alliance, even if it is a single provider number merged entity.

All the challenges for merging groups will continue when the pandemic crisis subsides. The problems may be even more extensive, given the economic hurdles. Increased capital is typically not a factor in a group merger other than some cost economies of scale. Usually, increased cash flow is realized later instead of in the near-term. Groups merge for other reasons too, such as the ability to project “strength in numbers” in payer contracting, vendor contracting, information technology (IT) contracting, hospital relations, etc., factors that will likely be taken into consideration during a merger. However, whether these factors will be sufficiently compelling for physicians to pursue merging is unknown.

As a result, physician-to-physician affiliation post-pandemic may assume the following characteristics:

1. Multispecialty group mergers, while always a difficult challenge, will not predominate in the marketplace in the immediate term.
2. Single-specialty mergers may create interest as an alternative, especially if hospital integration is not probable.
3. The reasons for merging will continue to exist post-pandemic, but because of financial and other more pressing needs, mergers among groups—single-specialty or otherwise—will be limited.
4. Mergers, though the interest may be limited, may be “legal only” structures with limited and/or deferred operational combinations.
5. Many physician groups will seek a private equity investor instead of or, in addition to, group mergers.

Physician-Investor Affiliation

Primarily, this option pertains to private equity (PE) firms investing in physician practices. Post-COVID-19 pandemic, the initial emphasis among the private equity firms, will address the economic challenges (reductions in profits) that resulted from the 2020 pandemic volume reductions. Most PE firms will be focusing what they already own and may not immediately consider new deals. However, the turnaround time and movement of PE firms to pursue further transactions will not be extensive. Two major reasons support this premise.

1. First, the PE firms that invest in other companies in other industries may prefer gravitating to healthcare. The volumes and growth in healthcare services will be better than most other industries.
2. Second, most PE firms still have significant capital to invest and may have even more when the pandemic subsides. PE investors will be looking for safe investment options. Medical practices and other healthcare consortiums would appear to be a reliable alternative.

Assuming PE firms will have a heightened interest—albeit delayed for up to six months post-pandemic to adjust to the pandemic crisis on their existing investments—how will these deals be structured? Typically, a PE firm will focus on earnings before income taxes, depreciation, and amortization (EBITDA) and, ultimately, negotiate a multiple tied-to-market dynamics and other variables, including aggregation of practices within a geographical area, to derive the up-front value. This multiple of EBITDA may be adjusted dramatically because of the COVID-19 pandemic (i.e., lower profits on existing investments) and a new metric referred to as EBITDAC. The “C” in this metric is for “COVID-19.” For instance, many PE firms will look for ways to reduce the earnings upon which they base the up-front value due to the COVID-19 pandemic and its effect on the bottom line.

Whether this matter is a legitimate consideration will be debatable and seriously negotiable. However, with less interest and/or the financial ability for hospitals and physician alignment, as well as fewer group mergers, the PE firms may have negotiating prowess to lower multiples and earnings upon which those multiples are based. The result may be lower valuations. The more substantial groups and healthcare provider consortiums will demand higher multiples, but there may be a period after the pandemic where values will be lower. Initially, the number of transactions may go down, but as physicians seek partners to mitigate risks of future uncertainty, they may accept lower valuations and, subsequently, lower sales prices. Additionally, private equity may require groups to retain a higher ownership percentage (although still a minority interest) as they look for a better valuation for all investors, including the physicians, within the “second bite of the apple” (i.e., the later sale).

Private equity will be a narrower option for groups. Only those that can internally sell the private equity concepts to their partners will pursue private equity deals.

From a physician-to-PE-investor standpoint, key areas in our post-COVID-19 forecast are as follows:

1. Private equity deals may be deferred for a short period as PE firms address existing investments.
2. Private equity firms will be involved substantially in the healthcare market.
3. Due to the abundant options from which PE firms choose, they will be highly selective and only align with top-performing groups and consortiums.
4. Physician groups and related healthcare entity sellers to private equity may have to retain more ownership (i.e., a larger minority interest) and be willing to accept lower multiples on EBITDAC.

5. In general, PE organizations will be aggressive, selective, and still subscribe to significant return on investment (ROI), placing pressure on the physicians to perform.
6. Physician groups will be challenged to convince their partners to pursue a PE transaction. No one will want the compensation reductions that result from PE deals, given the significant loss of income in 2020.

Valuation and Compensation Ramifications

Briefly, the key areas of consideration for valuation and compensation ramifications will be historical and future projected profits (i.e., EBITDAC) upon which valuations will be based, and the post-transaction compensation parameters. These include the pay reduction to create up-front earnings to mitigate COVID-19 pandemic losses. The up-front earnings opportunities work both ways as physicians seek opportunities to improve or restore their compensation, post-pandemic. At the same time, PE firms, hospitals, and other buyers of practices want to minimize their losses from employing physicians, given the pandemic’s economic stresses.

Valuation approaches for ongoing concerns will continue to focus on the market and income methodologies. However, the basis will reflect lower historical earnings and potentially more conservative future projections. Valuation firms must be savvy, stay on top of the latest trends in assigning multiples, and be adept at assessing financial and operational risk. On matters involving physician compensation, valuation firms may not factor, at least not to the historical level, industry benchmark survey data that has not had time to reflect COVID-19 pandemic effects on compensation and productivity. The past trends and precedents may (at least initially) require adjustment until the COVID-19 results are sufficiently documented.

Independent appraisal firms will still be at the focal point of the transactions and, as noted, should be up to date on the latest trends and the resulting assumptions that form the foundation of future valuations. This approach will apply to the economic terms and also their regulatory and legal ramifications.

Following are points to consider about post-pandemic physician compensation:

- » Guaranteed compensation *may* be lower.
- » Physicians *may* bear more risk for the relative same total compensation level.
- » Realizing a legitimate increase in compensation post-transaction *will be less* achievable.
- » Benchmark-sourced compensation rates *may* be lower than in previous years across many specialties.

Conclusions

With these key areas in mind, we continue to ask, “What is the new normal?” This question relates to physicians, hospitals, investors, and others’ interests in affiliation transactions. Will there be a rush to align with hospitals and other such entities? Will hospitals and private equity firms be a source of safety and security for physicians for the

future? Will security be more critical than economic improvement? Will physicians be willing to accept less from these purchasers in exchange for more protection from the next crisis? (In reality, hospitals and PE firms are not a guarantee of providing a safe-haven, especially considering that during the COVID-19 pandemic, many hospital-employed physicians had a reduction in pay.)

Generational dynamics among physicians is another factor in play. NextGen and Millennial generations are apt to continue to lean toward aggregation and consolidation. This group is inclined toward employment instead of independence and privatization. The Baby Boomers will continue to retire at a rapid pace, which may speed up due to the COVID-19 pandemic.

The new normal for post-pandemic crisis affiliations will be diverse, intricate, and not customized to the organizations involved. We anticipate a groundswell of interest toward alliances, especially with

hospitals and health systems. Nevertheless, there will be greater scrutiny based on economics, and valuations will be lower, at least initially. The level of activity in healthcare will be enormous post-pandemic. The key to thriving in the new environment will be for all the players to remain flexible and agile. No transaction should be forced, especially those that are not meant to be.

Endnotes

- 1 Susan Morse, *Telehealth to become permanent under Trump executive order*, HEALTHCARE FINANCE (Aug. 3, 2020), <https://www.healthcarefinancenews.com/news/telehealth-become-permanent-under-trump-executive-order>.
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1099 14th Street, Suite 925, Washington, DC 20005

www.americanhealthlaw.org

info@americanhealthlaw.org

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