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Dealer's Choice: Paving the Way for a Successful Pick-up

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Introduction

Deemed as robust, the 2022 mergers and acquisitions (M&A) market closed approximately 14% above 2021 volumes. According to Fierce Healthcare, 2022 (through 11/15) saw 2,277 healthcare deals valued at $127 billion.[1] Healthcare M&A is poised to continue to expand in 2023 with a focus, in part, on value-based care and attributed to significant levels of corporate cash and private equity "dry powder."[2]

Physicians will continue desiring to sell their practices for a variety of reasons. "There are three kinds of sellers: there is the seller who is retiring, there is the seller who is in distress, and there is the seller who is selling into growth or selling strategically."[3] Any one of these types of physician sellers will indeed consider selling their practice to a hospital/health system or private equity.

Physicians intending or desiring to sell their practice must consider many factors, including ensuring they are viewed as an attractive practice to be acquired. The following questions should therefore be considered:

1. How aligned are the practice's strategic goals with the buyer regarding market share, care delivery, and specialty?
2. Does the practice have well-documented financial information?
3. Is productivity consistent and financially beneficial across all providers in the group?
4. If retiring, is there a succession plan in place?
5. Does the practice have an electronic health records (EHR) system that can be converted to or is otherwise compatible with the buyer's EHR?
6. Does the practice have well-negotiated payer contracts?
7. Are advanced practice providers utilized to maximize efficiency?
8. Are profitable ancillary services being provided?[4]
9. Does the practice have in place an effective compliance program consistent with the size of the practice and the scope of services provided?

Given the Department of Justice's (DOJ) interest in holding private equity firms directly responsible for the actions of their portfolio companies when it comes to compliance with the False Claims Act (FCA),[5] these firms, as buyers, will be scrutinizing compliance practices and prioritizing accordingly.

An Effective Compliance Program

As early as 1991, the United States Federal Sentencing Guidelines have included the key components of a compliance program that need to be in place to mitigate punishment and reduce sentencing to a corporation. The guidelines were amended in 2004 and provide for the following:

A. Act with due diligence and the promotion of an organizational culture that encourages ethical conduct and a commitment to compliance with the law.

B. Have in place the following standards, which have become known as the "Seven Fundamental Elements" of an effective compliance program:[6]

   1. **Standards and Procedures:** Existence of standards and procedures to prevent and detect criminal conduct.
   2. **Governance and Oversight:** Designation of a compliance officer who is a high-level employee with adequate authority and resources to operate an effective compliance program.
   3. **Internal Enforcement and Discipline:** Efforts not to permit an individual to function as a high-level employee who has engaged in illegal conduct or otherwise who has acted in an unethical manner inconsistent with an effective compliance program.
   4. **Education and Training:** Effective training program on compliance and ethics to the governing body, high level, and all employees.
   5. **Monitoring and Auditing:** Have in place a program of auditing and monitoring and an anonymous reporting system for all employees to report potential or suspected compliance concerns. Periodically evaluate the effectiveness of the compliance program.

6. **Reporting:** Have in place appropriate incentives to perform in compliance and appropriate disciplinary measures that are consistently applied when compliance is not adhered to.
7. **Response and Prevention:** Appropriate response, mitigation, and program modification when noncompliance has been detected.[7]

C. Periodically assess organizational risk with respect to its compliance program.[8]

For the physician practice, the Office of Inspector General (OIG) published compliance guidelines in 2000,[9] restating the importance of the Seven Fundamental Elements and identifying pertinent risk areas applicable to physician practice groups. It also indicated that larger physician practice groups should follow the more robust compliance program measures laid out in its Third-Party Billing Company guidance.[10]

In terms of preparing to be viewed as an attractive seller from a compliance standpoint, several key areas should be considered.

Auditing and Monitoring

Proper coding is critical to maximizing revenue within a physician's practice and avoiding potentially costly repayments. In most transactions, a coding audit or revenue cycle analysis will be performed by the buyer as part of diligence and may identify one or more problematic practices, including overzealous and therefore overstated leveling of E/M services. Although rare, audits sometimes identify key concerns with significant seller liability that may be specific to the particular specialty.

The audit is the only sure method to confirm the compliance of the documentation and coding for a practice. A compliance audit does not simply verify that the codes reported were documented. There are many other areas of risk and opportunity found in a well-thought-out compliance audit. It is not uncommon to find that levels of evaluation and management services were reported with CPT codes that cannot be supported in the documentation. An audit may also show opportunities to report a higher level of service. This is an opportunity to educate providers with key strategies for applying documentation guidelines. Seller liability is often found in other areas, separate from the CPT and ICD10-CM coding. There are key areas that typically are discovered during a compliance diligence audit.

The most common findings as a result of a compliance audit include:

1. Variances in levels of E/M services reported versus documented.
2. Incorrect use of the modifier 25 when appended to an E/M service.
3. Incorrect reporting of "incident-to" services.
4. Incorrect reporting of ICD10-CM diagnosis codes.
5. Non-compliant or missing provider signatures.
6. Deficient documentation to support services reported.
7. Documentation that reflects providers copying and pasting documentation from prior encounters.

It is not uncommon for an audit to show that the documentation of evaluation and management (E/M) services either does not support the code reported or could support a higher level of service. The American Medical Association (AMA) developed new documentation guidelines that went into effect on January 1, 2021, followed by edits to those guidelines in March 2021.[11] The AMA has continued with its work in updating the guidelines for E/M codes, and on January 1, 2023, additional documentation guidelines have gone into effect.[12] With all the changes to the guidelines over the past years, providers are still experiencing a learning curve in applying all the definitions and rules that have come along with these guidelines. The need to audit the documentation of E/M services cannot be overlooked. The audit can also be performed to identify outliers within the practice. The outliers may be providers who often report much higher levels of service than their peers. The opposite may also be found. There may be a provider consistently reporting lower levels of service than their peers. Either outcome can be audited for accuracy and education. Insurance carriers typically base their requests for audits of provider documentation on claims data and the frequency of high levels of E/M services reported. This methodology can be used to determine any potential outliers and any potential need for paybacks later.

Currently, modifier 25 is under much scrutiny by all payers, not just federal programs. In 2021, the work plan created by the OIG included a specific effort to review certain claims with this modifier. The OIG titled this plan, "Audit for Dermatologist Claims for E/M services on Same Day as Minor Surgical Procedures."[13] The 25 modifier is appended to an E/M service when that service is significantly separate from a minor procedure performed during that same encounter. The provider documentation must reflect that the E/M service provided was a separate service. An auditor will compare the documentation found in the medical record to determine proper use of the modifier and will determine if the guidelines established by Medicare and the Medicare Administrative Contractor (MAC) for that region have been met. The audit will often indicate that the documentation does not support the reporting of a separate E/M service, and this has resulted in an overpayment that must be repaid.

It is difficult to identify the incorrect reporting of "incident-to" services without reviewing the documentation and signatures on the medical record. A payer will not recognize from a claim's submission that a non-physician provider (NPP) saw the patient in the office and provided the care that had been established by a physician at a prior encounter. An auditor will be able to verify that the rules of incident-to reporting were met.[14] The audit will be able to determine if the NPP saw a Medicare patient and created a new treatment plan without the involvement of a supervising physician and then reported the service under the National Provider Identifier (NPI) of a physician. An audit may also reveal that Medicare patients who are new to the practice are being seen by an NPP and the services are being reported under the NPI of a physician. Each of these scenarios will result in a payback to the Medicare program. The extent of the payback will, of course, be dependent upon the extent of the incorrect use of the incident-to rule within the practice.

An often-overlooked concern with provider documentation is the concept of copying information from a prior encounter note and bringing that information into the current encounter note without updating the information. This concept is often referred to as "cloning" or simply "copying and pasting." Per the Centers for Medicare & Medicaid (CMS), "[d]ocumentation is considered cloned when each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries."[15] In 2013, the OIG issued a report "Not All Recommended Fraud Safeguards Have Been Implemented in Hospital electronic health record (EHR) Technology."[16] This report outlines the overuse of cloning and lack of policies to address the concerns. This practice of cloning can lead to what is referred to as "note bloat." This is a medical record that includes information from other encounters that may not have even occurred during the current encounter. The result can be considered fraudulent documentation. Once an auditor identifies this activity, the integrity of the documentation begins to diminish. The auditor can determine if the pulling of information forward is being documented compliantly or if there are concerns that must be addressed.

Concerns that can be overlooked will come to light in a thorough audit. Auditors will confirm compliant signatures are being appended and can also indicate how many days it takes for a provider to sign a medical record. Although an incorrect signature should not result in a payback, it is essential to know in advance if the CMS policy on signature requirements is being followed.[17] If the practice has an internal policy that addresses when a medical record must be signed, an audit can confirm that information or reflect outliers of that policy.

Deficiencies in documentation for any type of service being reported can certainly be found during an audit. Often, providers use templates to document complex procedures or to document procedures that are frequently performed. When templates are used and the documentation is lacking key elements to support the CPT codes being reported, that can quickly result in many claims being reported with documentation that cannot support the services. Auditors will be able to identify any deficiencies in templated language and be able to identify any deficiencies in any procedure report. Deficiencies in documentation are not just related to procedures or a service. If the practice reports any injectable drugs, the exact name of the drug and dose must be documented. If providers perform any radiology or other testing in the office, the medical record must reflect the outcome of these tests. A thorough audit will identify where documentation is not supporting services that are being performed and reported.

Another area that can be identified during a complete compliance audit is the incorrect documentation of diagnoses and the incorrect reporting of ICD10-CM codes. Typically, the revenue into the practice is determined by the number or amount of relative value units (RVUs). that have been associated with a particular CPT code. However, a claim submitted with an incorrect or unspecified diagnosis code can result in a denied claim. The reviewing of the documentation in the medical record during the audit will identify any variances in either the documentation or the coding. When diagnosis codes are reported on a claim and are not supported by the documentation in the medical record, this can appear that the provider is attempting to support a higher level of E/M code by suggesting the patient had many conditions that had to be addressed. When ICD10-CM diagnosis codes are reported with a procedure and not documented, it may appear that the provider was reporting a diagnosis code that would assure medical necessity and therefore, allow a payment. An auditor will apply the ICD10-CM Official Guidelines for Coding and Reporting as established by CMS and the National Center for Health Statistics (NCHS)[18] when auditing the medical record to the claim information.

Not all audit findings are related to coding. A complete compliance audit will detect concerns that cannot be easily identified by simply reviewing claims data or reviewing a denial report. There are some variances that can only be identified by reviewing the documentation in the patient's medical record. The non-coding-related variances are often the cause of paybacks to the payer.

The outcome of any audit is opportunity. There is always an opportunity to educate staff and providers concerning correct coding, documentation, and billing. Audits provide an opportunity to identify where policies should be developed within the practice or realize it is time to perhaps audit an existing policy that is not being adhered to within the practice. Any aspect of the operations of the practice can be audited and therefore creates an opportunity for awareness and improvement. The outcome of a diligence audit may also be a decision not to pursue a practice for acquisition or a change in terms of the deal.

According to the United States Department of Health and Human Services (HHS), the government recovered four dollars ($4.00) for every dollar spent on healthcare-related fraud and abuse investigations during 2019-2021.[19] It is always beneficial to find an error before someone else finds that error. This is the biggest benefit of a complete, thorough compliance-driven diligence audit.

HIPAA Compliance

Physicians must understand and implement the requirements found in the Health Insurance Portability and Accountability Act (HIPAA) Privacy,[20] Security,[21] Breach Notification,[22] including the Omnibus Rule of 2013.[23] Since December 2000, there have been several modifications to the Privacy Rule. The largest modification was in January 2013 as part of the Omnibus Final Rule. The Security Rule was finalized in February of 2003 and was also modified by the Omnibus Final Rule (collectively, these are the "HIPAA Rules").

The HIPAA Rules were developed to protect the confidentiality, integrity, and availability of data. *Confidentiality* means that information is only accessible to authorized users. *Integrity* means safeguarding the accuracy and completeness of data and processing methods. *Availability* means ensuring that authorized users have access to data when needed.[24]

With the increased occurrence of cyber threats on healthcare organizations, the due diligence process will most certainly include a review of the seller's compliance with HIPAA including any previous violations, specifically with the requirements of the Privacy, Security, and Breach Notification rules including the Omnibus Rule from January 2013. Physicians should have in place an effective HIPAA compliance

program that includes all safeguards required to appropriately protect all protected health information (PHI).

Some commonly requested due diligence items include policies and procedures, the Notice of Privacy Practices, training materials and logs, and a list of Business Associates. Physician practices should review these documents to ensure they are up to date. The due diligence process will also focus on past privacy and security incidents and security risk analysis.

One way a physician practice can prepare for the due diligence process is to conduct its own self-assessment. In July 2018, the Office for Civil Rights updated its audit protocol.[25] The protocol is an excellent resource and can be used to help assess compliance with all three HIPAA rules including changes incorporated into them with the Omnibus Rule.

Physician Practice HIPAA Program Structure

An effective HIPAA program for the physician practice includes many important elements. The practice should appoint someone responsible for the HIPAA Privacy and Security program. This person(s) should be knowledgeable in all areas of HIPAA and the functional areas of the practice. Their primary role will be to develop, implement, and maintain the practice's policies and procedures, serve as the primary point of contact for complaints and incidents, track and document all investigations and outcomes, and manage breach notification. Monitoring compliance with established policies and procedures is continuous and can help to identify areas of noncompliance and/or risk. A complete review should also be conducted any time process or systems changes.

Often, practices will have well-known and repeatable practices in place but fail to formally document them. In addition to the required policies and procedures established by HIPAA, practices should ensure that any practice-specific policies and procedures are documented as well. Policies and procedures should be available to the practice's workforce members. They can be printed and placed in a binder for easy access or be made electronically available.

Practices must ensure that workforce members are trained on all elements of HIPAA compliance. Training should be conducted during initial onboarding and at least annually thereafter. Training should also be job specific. Training attendance can be tracked by either using a simple sign-in sheet or a more robust training program. Periodic security reminders throughout the year are an effective way to get key workforce members engaged. Reminders can be in the form of monthly emails, included as an agenda item during regular meetings, or in response to industry bulletins.

The lack of a qualified security risk analysis is the most frequent area of identified non-compliance during a diligence review. In December 2020, the Office for Civil Rights (OCR) published the results of the 2016-2017 HIPAA Audit.[26] Of the 166 Covered Entities (CE) and Business Associates (BA) the OCR audited, only a small percentage, 14% of CEs and 17% of BAs, were compliant with conducting a Security Risk Analysis (SRA) that meets the requirements outlined in the security rule (164.308(a)(1)(ii)(A)).

According to the audit, entities generally failed to identify and assess the risks to all the electronic PHI (ePHI), develop and implement an SRA policy and procedure, identify threats and vulnerabilities, review and periodically update their SRA, and conduct their SRA consistent with policies and procedures.

The OCR provides guidance on conducting a risk analysis,[27] which was adapted from the National Institute of Standards and Technology (NIST) Special Publication (SP) 800-66 and NIST (SP) 800-30.[28] The scope of the security risk analysis should consider risks and vulnerabilities to the confidentiality, availability, and integrity of all ePHI. All assets that access, store, and transmit ePHI (e.g., workstations, servers, medical devices, multi-function machines, applications, etc.) should be identified. After assets are identified, all threats and vulnerabilities will need to be assessed.

In its guidance, OCR defines a threat as:

> "[t]he potential for a person or thing to exercise (accidentally trigger or intentionally exploit) a specific vulnerability[.]"as "[a] flaw or weakness in system security procedures, design, implementation, or internal controls that could be exercised (accidentally triggered or intentionally exploited) and result in a security breach or a violation of the system's security policy[.]" (e.g., outdated software, unpatched systems, etc.), and a risk as "the probability that a particular [threat] will exercise (accidentally trigger or intentionally exploit) a particular [vulnerability] . . .".[29]

Conducting a physical walkthrough to identify potential risks to paper records and verbal communications is another key component of an SRA.

SRA findings should be formally documented and shared with the physician partners. An SRA should be completed or updated at least annually due to the ever-changing landscape of information technology. Moreover, the risk analysis process should be ongoing in order for an entity to update and document its ongoing security measures.[30] New applications should be evaluated as they are implemented. The SRA findings should be used to develop a risk remediation plan that addresses the risks identified and to track risk remediation efforts.

Another common area of noncompliance relates to providing a copy of the practice's Notice of Privacy Practices on the practice's website and to its patients. HHS has provided model notices and guidance on its website.[31]

In addition to explaining how the patient's information may be used and disclosed, the notice should also explain how a patient can submit questions or complaints. All complaints should be logged including the outcome of the investigation as well as breach notification dates. Individual breach notification must be provided to patients no later than 60 days.[32] The Breach Notification Rule has very specific implementation specifications and should be reviewed when evaluating compliance. HHS provides an excellent resource on its website.[33]

Last, but certainly not least, a formal process should be in place to ensure business associates are required to safeguard PHI they create, receive, maintain, or transmit on behalf of the physician practice. The Omnibus Rule placed more requirements on business associates and

the content of the business associate agreements. A sample agreement can be found on HHS's website.[34]

Merit–Based Incentive Payment System Attestation

An often-overlooked area identified during diligence is the impact that failure to meet the security risk analysis rules has on other payment programs. Conducting an SRA is also required for participants of the CMS Merit-Based Incentive Payment System (MIPS). MIPS combines three previous programs: the Physician Quality Reporting System (PQRS), the Value-based Payment Modifier (VM) Program, and the Medicare EHR Incentive Program (Meaningful Use) into a single payment program. The MIPS quick start guide is available on their website.[35]

As a gateway element, MIPS participants must report a "yes" to the Office of the National Coordinator for Health Information Technology Direct Review Attestation, SAFER Guides, and the Security Risk Analysis measures. A physician or physician practice group participating in MIPS and realizing bonuses may be placing incentive monies at risk where there has been a failure to perform an SRA yet attested to having completed it. A strong cybersecurity program with up-to-date policies and procedures, a current security risk analysis, and remediation plan in place demonstrates the importance one has on protecting patient data.

Conclusion

Physicians desiring to sell their practice can successfully position themselves for a successful sale by performing a pre-offer review of key compliance areas specific to their practice. The existence of a compliance program with documented measures of its effectiveness could place the seller physician practice group in a buyer's top priority category.

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2023 Outlook: Healthcare M&A

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Rising interest rates, elevated inflation, and economic uncertainty led to volatility in 2022, and many of these factors remain in place heading into 2023. While inflation appears to have peaked and is trending lower, the full impact of the rapid rise of interest rates has yet to be felt throughout the broader economy. Questions about interest rates and whether the United States economy will enter a recession will continue to linger throughout 2023.

Within the healthcare industry, valuation multiples and stock prices for public companies declined along with the broader market in 2022. Although the public markets had a difficult year, healthcare merger and acquisition (M&A) activity continued at a robust pace in 2022 (with the exception of hospital M&A, which hit multi-year lows), with deal volume increasing year-over-year compared to 2021.[1] The following charts present the enterprise value-to-EBITDA[2] multiple for the S&P 500 Health Care Sector Index (HCX)[3] and the yield on 10-year United States Treasuries[4] throughout 2022

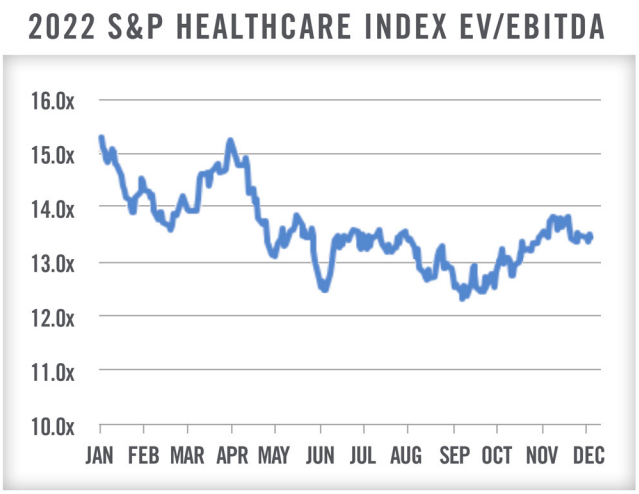

Figure 1: 2022 S&P Healthcare Index EV/EBITDA

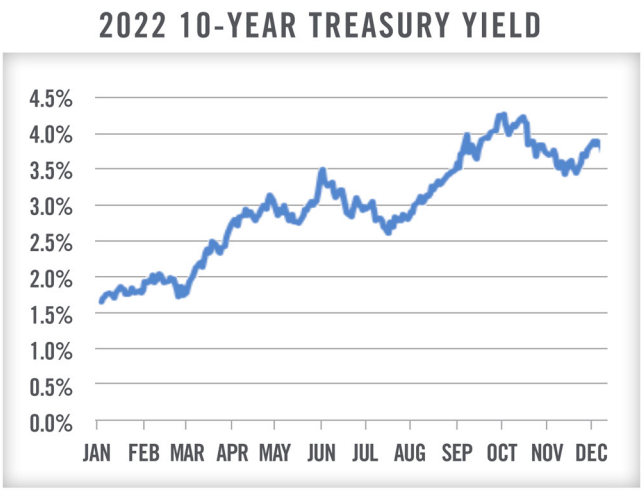

Figure 2: 2022 10-Year Treasury Yield

Key Questions for 2023

Will Physician Practice Consolidation Activity Continue?

Despite the economic and financial market headwinds in 2022, healthcare M&A volume remained strong with many of the trends from past years continuing, as evidenced by physician practice transactions having been a key driver of overall healthcare deal volume. Driven primarily by private equity physician practice management (PPM) transactions, physician practices comprised 30 percent of total healthcare deal volume in the previous year.

Several factors could affect deal volume in 2023, including higher cost of capital for private equity groups, economic uncertainty, and recent Medicare reimbursement cuts that could impact budgets and lead to fewer health system acquisitions. However, many market participants expect physician practice deal volume to remain robust for a variety of reasons, such as the desire to consolidate within specific specialties and continued focus from health systems to expand their physician networks (discussed in more detail in following sections).

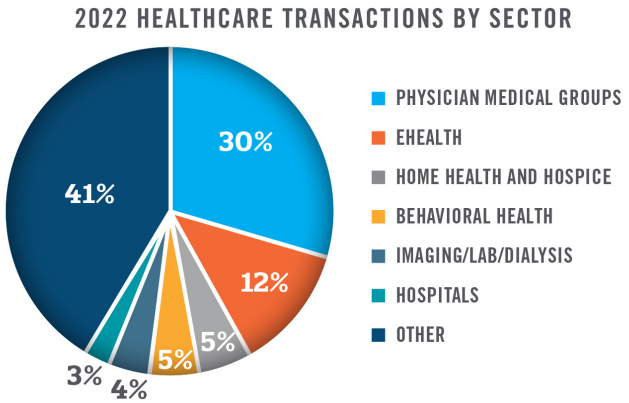

Figure 3: 2022 Healthcare Transactions by Sector

High levels of activity are anticipated to continue in a number of medical specialties, such as orthopedics, cardiology, and gastroenterology. Private equity activity in the orthopedics space has been growing in recent years, and their valuation multiples have increased to the low double-digit range. While a high volume of deal activity will likely continue with ophthalmology and dermatology, we expect to continue seeing large platforms transact as these specialties have been undergoing consolidation since the early 2010s. Interest in behavioral health providers is strong, based on what we hear from clients and our observations in the marketplace.

MEDICAL SPECIALTY	TRANSACTION VOLUME	% OF TRANSACTION VOLUME
DENTAL	217	38%
OTHER SPECIALIST	108	19%
OPHTHALMOLOGY	83	15%
ORTHOPEDICS	34	6%
PRIMARY CARE	34	6%
DERMATOLOGY	34	6%
GASTROENTEROLOGY	27	5%
FERTILITY	24	4%
CARDIOLOGY	11	2%

Figure 4: Transaction Volume by Specialty for 2022[5]

While private equity has been driving most of the deal volume in the physician practice sector, health systems are increasingly interested in competing with private equity for certain transactions. For example, health systems have implemented or are considering ownership models of practices at either the controlling or non-controlling level in which physicians maintain ownership interest and retain a higher degree of autonomy and governance. While these models do not include rollover equity like private equity PPM transactions, they may include profit-based compensation plans and typically leverage the system's payor contracts and supplies arrangements. Historically, many large hospitals and health systems have structured physician practice acquisitions based on tangible asset value plus an increase in go-forward compensation for the selling providers (and employed providers). With private equity and other buyers active in the industry, hospitals and health systems have had difficulty competing given the multiples other acquirers are willing to offer. To close transactions, hospitals and health systems are increasingly willing to pay practices for intangible assets that they may not have considered in the past. Attributes that contribute to intangible value at physician practices include but are not limited to the following: having a large number of employed providers, level of difficulty in recreating a practice, ancillary revenue streams, favorable contracts, and other unique situations.

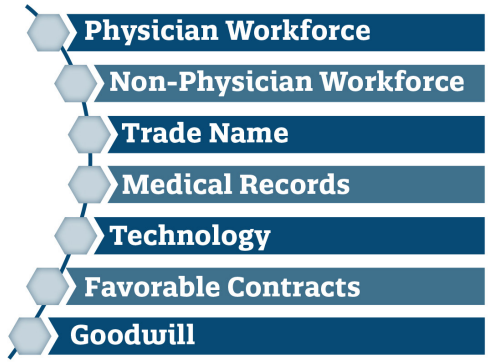

Figure 5: Intangible Assets Commonly Valued in Health System-led Physician Practice Acquisitions

What Will Happen to Valuation Multiples?

While public market valuation multiples declined by approximately 12 percent, the average healthcare transaction multiple declined by approximately 9 percent in 2022.[6] While every transaction is unique, declines in valuation multiples across the industry are largely attributable to higher interest rates, coupled with the fact that many subsectors of the healthcare industry had seen valuation multiples reach elevated levels in recent years.

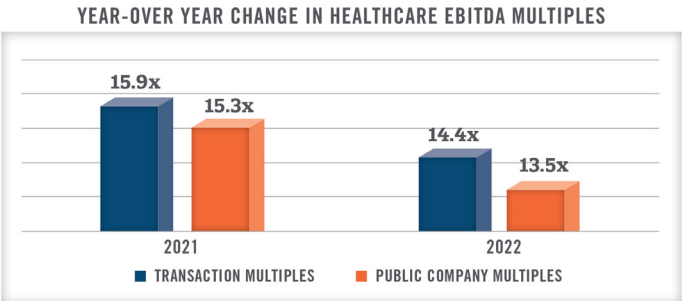

Figure 6: Year-Over Year Change in Healthcare EBITDA Multiples

The outlook for interest rates suggests that the cost of capital will continue increasing, with many projections from Wall Street firms and the Federal Reserve's "dot plot" suggesting that short term rates will increase from approximately 4 percent at the end of 2022 to 5 percent in 2023.[7] In addition, the full impact of higher rates has not yet made its way through the economy as many borrowers took advantage of lower interest rates prior to the recent increases. While these factors suggest that valuation multiples will likely be flat or lower in 2023, many buyers continue to be strategic, and the scarcity of certain types of providers in certain markets leads to competition for deals. For example, assets that are unlikely to see lower valuations in 2023 include platform-size physician practices (particularly those in orthopedics, cardiology, and gastroenterology), orthopedic-focused or other highly profitable surgery centers, and women's care/IVF providers. Among newer healthcare companies that are not currently profitable, but which are trying to raise capital in 2023, we believe they will experience down rounds (raising capital at lower valuations than prior capital raises) or be acquired in distressed sales.

Home Health and Hospice

The M&A landscape in home health and hospice in 2022 was characterized by a decline in overall volume, but two large transactions led to higher overall deal value compared to 2021. The UnitedHealth acquisition of LHC Group and the CVS acquisition of Signify Health represented approximately $14 billion in total transaction value that caused overall deal value to increase more than 70 percent, even though volume fell by more than 25 percent.[8] In 2023, market participants expect a rebound in deal volume given the high level of interest in Medicare certified home health and hospice, as well as private duty nursing and personal care, from private equity and other strategic buyers. The bar graph in Figure 7 presents the share price increase or decrease for each of the publicly traded home health and hospice operators for 2022. We note that CVS announced its intended acquisition of Signify Health in September of 2022.

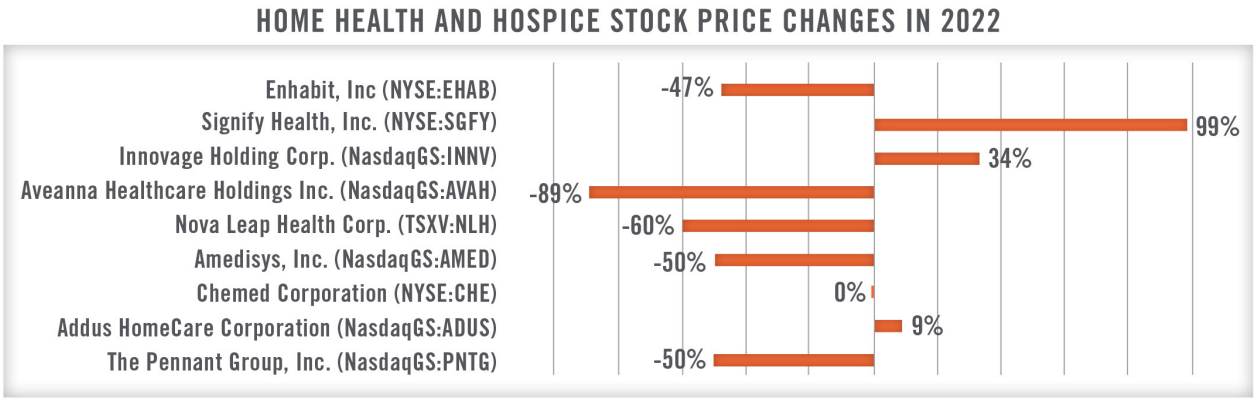

Figure 7: Home Health and Hospice Stock Price Changes in 2022

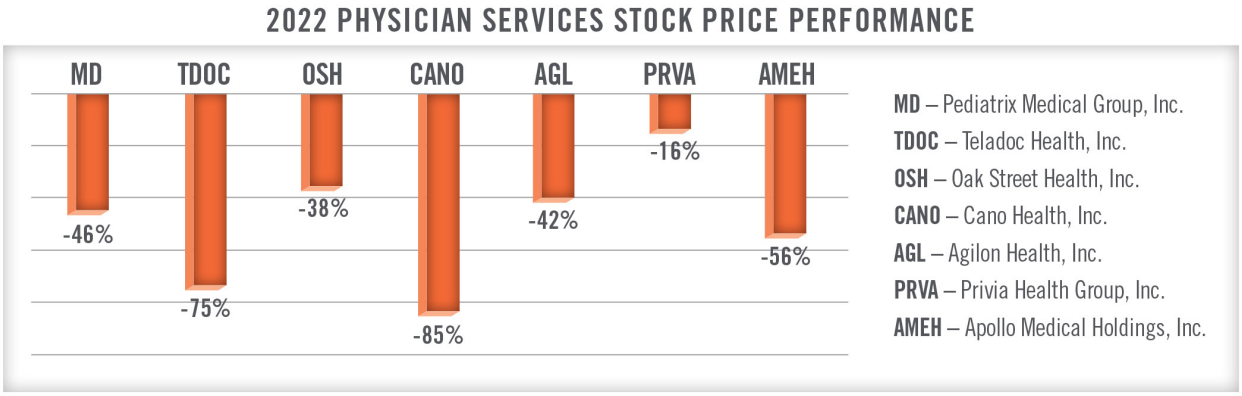

Figure 8: 2022 Physician Services Stock Price Performance

Public Physician Practice Management/Medicare Advantage

2022 was an exciting year for the publicly traded companies focused on value-based care and physician services, and we expect more activity in this sector in 2023. Cano Health (CANO) was in discussions to be acquired by CVS or Humana, although neither company closed a transaction. More recently, CANO's debt was downgraded by Moody's, and it has been rumored to be nearing bankruptcy. Oak Street Health (OSH) is currently in discussions to be acquired by CVS for approximately $10 billion, according to Bloomberg,[9] and Amazon announced plans to acquire One Medical (ONEM) in July of 2022. While not publicly traded, Carbon Health recently raised $100 million from CVS at an undisclosed valuation, although we note the investment came shortly after Carbon Health announced a large layoff. The ability to achieve rapid scale in a sector that is critical in the shift to value-based care is likely to lead to additional interest in the sector from large acquirers in 2023. With the stock prices of many operators down more than 40 percent in 2022, potential acquirers may view these companies as offering an attractive entry point.

Will Deal Structures Be Impacted by Higher Interest Rates?

As entities enter an environment where raising capital becomes more difficult, we have observed, in recent months, a push by startups and early-stage companies towards acquisitions requiring less upfront cash. For example, alternative deal terms have included stock transactions, long-term promissory notes, and a higher percentage of consideration pushed into an earnout structure. With capital markets tighter than they have been in recent years, early-stage companies will likely continue to focus on conserving cash and look to implement deal structures that help accomplish this goal. We have also observed increased use of right of first refusals (ROFRs) and call options—including long-term call and put options—by prospective buyers. These ROFRs and options enable acquirers to conserve cash and push potential acquisitions to a later date with less risk of losing out on the transaction. More broadly, we have observed more buyer friendly deal structures and transaction processes as acquirers have started facing less competition for targets.

1 *LevinPro HC*, Levin Associates, 2023, February, levinassociates.com.
2 EBITDA stands for Earnings Before Interest, Taxes, Depreciation, and Amortization.
3 S&P Dow Jones Indices, S&P 500 Health Care, https://www.spglobal.com/spdji/en/indices/equity/sp-500-health-care-sector/#overview (last visited Mar. 15, 2023).
4 FRED Econ. Data | St. Louis Fed., *Market Yield on U.S. Treasury Securities at 10-Year Constant Maturity, Quoted on an Investment Basis*, Econ. Research Fed. Reserve Bank of St. Louis, https://fred.stlouisfed.org/series/DGS10# (last visited Mar. 13, 2023).
5 *LevinPro HC*, *supra* note 1.
6 pwc, *Health services: US Deals 2023 outlook*, https://www.pwc.com/us/en/industries/health-industries/library/health-services-deals-outlook.html (last visited Mar. 13, 2023).
7 Fed. Open Mkt. Comm., *Summary of Econ. Projections*, Bd. of Governors of the Fed. Reserve Sys., The Federal Reserve (Dec. 14, 2022, 2:00 pm EDT), https://www.federalreserve.gov/monetarypolicy/fomcprojtabl20221214.htm.
8 pwc, *supra* note 6.
9 Michelle F. Davis, et al., *CVS Is Exploring a $10 Billion-Plus Acquisition of Oak Street Health* (Jan. 9, 2023), Bloomberg, https://www.bloomberg.com/news/articles/2023-01-09/cvs-is-said-to-explore-acquisition-of-oak-street-health (last updated Jan. 10, 2023).

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Check out Neal's article about Medical Directorships and APP Supervision and **learn more about best practices for combating issues in the marketplace today.**

Compliance & Best Practices: Medical Directorships and APP Supervision

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Many of the hospitals and health systems that HSG consults with on provider compensation, employed practice operations, and hospital-based services arrangements lack a robust strategy and/or approach for managing and reviewing compliance related to physician agreements for medical directorships and advanced practice providers' (APP) collaboration and supervision. Because these functions are typically outside of (or ancillary to) an agreement for clinical/direct patient care services (the primary focus of the agreement), they often do not receive the oversight and attention they deserve. Hospitals and health systems across the industry often, inappropriately, view these agreements as legitimate mechanisms through which the compensation of a physician, or group of physicians (if referring to a Professional Services Agreement (PSA) for clinical services) can be "padded." A fair share of these organizations has admitted that the proliferation of these types of arrangements escaped the control of their management. One slightly frustrated health system executive quipped, "we've passed out medical directorships like candy."

In this article, we will review the concerns and problems we've encountered through our consulting work with hospitals and health systems across the country. First, we will focus on some common missteps (what not to do), followed by a discussion of best practices for management and compliance connected with medical directorships and APP oversight programs and associated stipends.

Medical Directorships Program (What Not to Do)

Between medical directorships and APP collaboration/supervision agreements, medical directorships certainly seem like they've been around for ages. We frequently encounter legacy medical directorship arrangements, as well as legacy approaches to their management. An age-old complaint we hear with medical directorships is, "they (physicians) don't like having to track their time" or "they're too busy to document their time." This is an area that needs to be non-negotiable from the regulatory standpoint but unfortunately, that is not always the case. From our perspective, there are two factors that tend to complicate time tracking and reporting:

The first factor occurs when hospitals and health systems do not provide their physicians with the tools to make the process easier. This topic is not merely about software programs, smartphone applications, or a spreadsheet; it also includes something far simpler: the standard paper timesheet.

The second factor involves a lack of physician education on the importance of tracking and reporting dedicated medical director time to their organization. Leaders who do not explain how time reporting benefits both the individual and the organization are setting themselves up for failure and frustration. Some of the busiest physicians have no problem reporting their time accurately and on a timely basis. They do so because they understand the importance of the task and take it seriously. Where there is a will, there is a way, especially if they are assisted in the process!

Physicians should not shoulder all the blame when it comes to not taking medical directorship management seriously—hospital administration is responsible and accountable as well. In our audits of medical directorship "programs," we've compared submitted timesheets with the duties and responsibilities specified in medical director agreements. Submitting as documentation "sent email to Dr. Smith" or "meeting with service line leader" is not sufficient detail to justify completion of specific duties and expectations in a medical director job description. The documented tasks need to be linked with and represent required activities, such as "Assisted the Hospital in assuring the Imaging and Outpatient Radiology Services comply with the standards of The Joint Commission, licensure requirements, Medicaid and Medicare standards, and state licensing surveys by completing a review of Outpatient Radiology policies and procedures" or "Participated in Oncology Service Line quality assurance and improvement activities by leading the quarterly service line meeting to review quality data." The activities noted in the cryptic entries may in fact represent direct medical director activities, but the entries do not delineate the connection . . . the "why." Despite the

lack of detail and specificity, we have seen many timesheets with the aforementioned sparse level of detail that were approved for payment by hospital management. Both medical directors and responsible management need to be held accountable for complying with appropriate tracking and reporting standards.

We previously mentioned legacy medical directorships. A common issue we encounter in this regard is a lack of periodic review for relevance and need. All too often, medical directorships are allowed to continue even though their relevance, importance, and organizational need no longer exist, or ever existed in the first place. Perhaps the hospital now has a co-management agreement in place and the leadership and guidance that was once provided by a single medical directorship is now provided through a group of physicians who are all part of a co-management arrangement, which may make the medical directorship redundant and an unnecessary added expense. In either case, allowing a medical directorship to auto-renew without periodic review for relevance is problematic, as an intentional review is the only realistic mechanism to ensure continued pertinence.

Another common issue is using a medical directorship as a compensation band-aid, i.e., adding to total compensation through a separate mechanism. This practice forms a critical element of compliance scrutiny, which can be addressed through a couple of actions: the aforementioned reviews for necessity and through established fair market value (FMV) and commercial reasonableness processes. Most hospitals and health systems now know that separate medical director compensation market data and surveys exist; those specialty-specific rates are not the same as that which a physician can earn in his or her clinical capacity. However, while organizations know this on one level, they often lack reliable processes to regularly review market data and fair market values.

An additional factor is the "reasonableness" criteria and whether accomplishing the medical directorship responsibilities is even feasible. For some physicians, adding medical directorship responsibilities on top of their already-demanding clinical activities may be exceptionally challenging, some would even argue not humanly impossible. Hospitals should ask themselves whether physicians who are producing and earning well above the 90th percentile are the best candidates for a medical director role. Can they commit enough time and effort that the position needs and deserves? Does the organization want the compliance risk of adding more compensation to a physician who is already well above the 90th percentile for his or her specialty?

Lastly, naming a physician as the medical director of his or her own outpatient practice is, in our experience, a uniformly bad idea because normal day-to-day office tasks find their way into a timesheet. While physician leadership at the point of care is necessary and indispensable, drawing the line between normal clinical administrative duties in daily practice and actual administrative leadership can become blurred, and everything that is not directly related to seeing/treating a patient cannot become a billable medical director activity.

Medical Directorship Program (Best Practices)

Now that we've talked about some of the issues and concerns that we encounter in our consulting work, let's review some best practices related to creating practical, sustainable, mutually beneficial and compliant medical directorships.

1. **Educate and communicate.** Communicate to your physicians the importance of demonstrating compliance related to tracking and reporting of medical director time. Provide group educational sessions that cover medical directorships and other compliance-related topics. Provide one-on-one medical director education regarding what to do and how to do it when medical directorship agreements are executed. In addition, ensure that organizational policies and procedures related to medical directorships explicitly contain background information about the federal rules and regulations governing hospital-physician relationships and compensation arrangements, such as medical directorships. Promote educational references for both the involved physicians and administrative management.
2. **Provide tools and resources for time tracking and reporting.** Hospital and health system executives need to provide physicians with the tools and resources they need to be successful and compliant in both their clinical and administrative duties. This is especially true when the physicians have been contracted to provide clinical leadership and expertise in a medical director role. One of the most "obvious" areas of assistance is related to time tracking and reporting. Providing a simple hard copy timesheet that delineates the various medical director duties for easy selection and comment may serve this purpose. However, the process can be streamlined for all involved by utilizing a technological solution. One example is provided by the technology company Ludi[1] and its DocTime[2] suite of technology solutions that enables physicians to track their medical director time via smartphone mobile app, tablet, laptop, and/or desktop computer. The DocTime suite also provides a seamless platform for managing physician compensation calculations and payments on the backend.
3. **Have someone "close to the action" review submitted timesheets.** Even organizations that have a process by which someone in administration/management reviews medical director timesheets prior to stipend payment often do not go "far enough" in their reviews. In these instances, the person reviewing the timesheet is usually not "close enough" to the medical director or the hospital function or service line for which the physician is providing direction. In other words, he or she neither sees nor interacts with the medical director—or even with other leaders or staff who interact with the medical director—on a daily, weekly, or even monthly basis. As a result, they don't truly know if the work is being done, i.e., routinely attending required meetings, educating staff, acting as a liaison between the hospital and referring physicians, and fulfilling the host of other duties required of medical directors.

To have the timesheet review process add meaningful value, assign the review process to someone with intimate knowledge of the role, function, and/or service line. That individual should also be required to sign the timesheet after completion of review.

4. **Make sure timesheets reflect the job description.** As mentioned previously, "sent email to Dr. Smith" or "meeting with service line leader" does not provide enough detail to indicate fulfilment of medical director responsibilities. Do these statements reflect any of the duties provided in a medical director job description, and in what context? Perhaps the medical director was thinking of a specific task from the job description when she made her documentation but without further details, who can tell? The tasks and services documented by the physician must clearly align with the job description. As stated in best practice number two (2) above, by providing physicians with the resources and tools they need to make the fulfillment of their director-related jobs easier (e.g., a technology-based solution or a timesheet with the duties already listed and prepopulated), they will more likely be consistent and compliant with their timesheets.

   Additionally, ensure that timesheets that do not document fulfillment of the job description are not blanketly approved. If the timesheet submission is not adequate, circle back to best practice number one (1) and educate the medical director as to why the submission is inadequate and what is expected now and in the future. Only after a satisfactory timesheet is submitted should the stipend be approved for payment.

5. **Periodically audit timesheets for accuracy, completeness, and relevance.** An audit process and detailed evaluation for relevance should be undertaken at least every three (3) years, to review compliance with timesheet submission and completeness expectations. Does the timesheet accurately reflect the current position description responsibilities? Do completed/submitted timesheets fulfill the position's dedicated hour and activity requirements? Have the timesheets gone through the full approval process with necessary review/signatures before stipend payments were authorized? Discovered deviations represent opportunities for timesheet revision, process revision, or execution education.

6. **Periodically review compensation rates for fair market value.** Typically, our FMV opinions are valid for three (3) years. As such, we'd recommend reevaluating your medical director rates, expected hours, and total compensation limits at least every three (3) years. Provided in Figure 1 is a three (3) year trend of medical director hourly compensation data that was extracted from MGMA's Medical Directorship Compensation 2022 Report Based on 2021 Data via MGMA's DataDive platform. The table presents the median hourly compensation rate for eight (8) common specialties as reported for data years 2019, 2020, and 2021. The data shows some significant increases, some noteworthy decreases, and some that have not changed at all. We also recommend following Stark III guidance, i.e., that "reference to multiple, objective, independently published salary surveys remain a prudent practice for evaluating fair market value." Therefore, other available surveys and local or regional sources should also be consulted and evaluated during these reviews.

Medical Directorship Compensation

2022 REPORT BASED ON 2021 DATA

Hourly Rate Compensation Trending

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For resources and definitions, visit mgma.com/datadiveresources

Specialty	2019 50th %tile	2020 50th %tile	2021 50th %tile	Overall
Anesthesiology: All	$200.00	$205.68	$166.67	-16.67%
Emergency Medicine	$187.00	$163.62	$183.04	-2.12%
Family Medicine: All	$126.97	$137.09	$146.61	15.47%
Hematology/Oncology	$200.00	$197.69	$223.07	11.54%
Internal Medicine	$126.00	$150.00	$150.00	19.05%
Obstetrics/Gynecology	$150.00	$150.00	$150.00	*
Pediatrics: General	$133.00	$125.00	$125.00	-6.02%
Surgery: General	$163.00	$175.00	$180.00	10.43%

Figure 1. Medical Directorship Compensation, 2022 REPORT BASED ON 2021 DATA, Hourly Rate Compensation Trending

Source: 2022 MGMA DataDive Medical Directorship Compensation, based on 2021 data. Used with permission from MGMA. Copyright 2022. www.mgma.com/data.

7. **Ensure no duplication or overlap with other agreements.** Overlapping can be extreme, such as two (2) physicians having the same medical director role when only one (1) is needed, or less extreme, such as the overlapping of a few tasks or duties in two (2) separate medical directorships. The former is more acute, but both are problematic from a compliance perspective and should be dealt with appropriately.

   Overlapping can also occur when new and different agreements are introduced. Perhaps your hospital decides that a co-management agreement in orthopedics is necessary to unify disparate orthopedic groups to tackle the process of care, quality and outcomes, cost of care, patient satisfaction, and variations in transitions of care and appliance utilization. Historically, these efforts were handled at your facility by the orthopedic service line medical director, who would also participate in the co-management agreement. Would that medical director have held on to his or her medical directorship? The answer is usually not in the form it currently exists or at the level it once did. Duties that could exist outside the co-management arrangement should be rolled into the co-management arrangement, which could also include a newly defined lead or directorship role within the arrangement.

8. **Don't use a medical directorship merely as a vehicle to increase compensation.** Imagine the following scenario, which has often played out in reality between physician and hospital: a physician really wants to earn $350,000, but the hospital is not comfortable going above $300,000 in base salary, which an FMV and commercial reasonableness opinion supports. Despite the

physician's desire for a higher base salary, the hospital should not create a medical directorship role to merely "pad" a physician's compensation. If the hospital has not already determined a legitimate need for a medical director, subsequently creating such need to fulfill a physician's desire for a higher base salary will not be received well by others and is difficult to justify.

9. **Don't use a medical directorship to obtain or encourage leadership in a practice.** Asking a physician to count his or her hours for every administrative interaction or expression of leadership on a daily basis is not the way to encourage leadership within an individual practice or broader physician network. This mindset may be an outgrowth of best practice number eight (8) above or a reaction to a physician who has expressed the belief that any non-revenue- or wRVU-production bonus-generating activities should be compensated separately and on top of "clinical compensation," otherwise, "why would someone put up with it?" First of all, such a mindset and attitude are probably not reflective of someone a hospital would want to lead a vitally important practice in its physician network. Secondly, perhaps there is something amiss with the structure of the physician compensation model's incentives if wRVU bonuses and production are the only motivators.

APP Oversight Program (What Not to Do)

As previously noted, we commonly encounter organizations that do not have robust oversight programs related to APP collaboration and supervision. These organizations risk noncompliance with state regulatory requirements as well as physician compensation requirements related to collaboration/supervision stipends. While medical directorship programs have already garnered national scrutiny, APP oversight programs are ripe to be next in the physician compensation external audit spotlight.

States regulate APP oversight and typically generate broad guidance regarding the minimum expectations that must be met, regardless of practice type or location of care within the state. Organizational requirements can be more stringent than the state regulatory requirements but must comply with the published minimum state requirements. Not all states have the same requirements, so it is important to have a working knowledge of what is required in your state and keep abreast of changes to ensure ongoing regulatory compliance. Many organizations have not identified an individual(s) responsible for knowing current state requirements and ensuring that the organization's program fulfills those requirements. This is the first potential programmatic gap in APP oversight.

A second area of concern arises when the organization does not create specific parameters or programmatic elements to implement the broad state requirements in a detailed, facility-specific manner. A common example is related to "quality of care reviews," which are required by most states' regulations but are not specifically defined by many of them. The state often delegates the details of "quality of care reviews" to the organization, which often fails to specifically do so through collaboration agreements or policy. Another example involves "written protocols" or scopes of practice, whose requirements may be stated in a collaboration agreement but without any defining details.

Organizations that define "quality of care reviews" through specific chart review requirements often face physician resistance as the process represents "yet another" time-consuming requirement that impacts work-life balance and burnout risk. Creating realistic requirements, providing tools to more readily accomplish and document the reviews, linking the reviews with systemic quality and privileging programs, promoting APP mentorship, and rewarding the extra effort through APP collaboration/supervision stipends can help offset these concerns.

Finally, some organizations have implemented APP collaboration/supervision stipends for physicians without defining the requirements for a stipend payment or having a process in place to monitor compliance with stipend requirements, including state regulation mandates. The former represents a federal Stark compliance risk while the latter represents a state regulatory compliance risk. In addition, many organizations neither utilize external benchmarking or obtain FMV opinions when establishing stipend amounts nor determine their impact on total compensation.

APP Oversight Program (Best Practices)

As is done for medical directorships, proposed best practices can address issues and concerns presented in APP collaboration and supervision situations. The ultimate goal is to establish and maintain a practical, sustainable, mutually beneficial, compliant APP oversight program.

1. **Develop a robust policy that comprehensively defines the organization's APP Oversight Program.** An effective policy should clearly define roles and responsibilities while establishing the specific parameters and expectations for the APP Oversight Program and apply them across the entire organization.

   Key elements to outline in the policy include, but would not be limited to, the following:

   a) Program management/coordination
   b) Physician collaborator/supervision assignment and limitations
   c) Documentation submission/retention requirements
   d) Program parameter compliance and quality monitoring process

Details related to each of these elements are expounded upon in the following paragraphs.

Program management and coordination should fall under a designated APP Oversight Program Manager with specifically defined responsibilities for which the individual is accountable. Some of these responsibilities would include:

a) Ensuring that state-required forms are initially submitted and/or renewed in a timely manner and in accordance with state regulations.
b) Maintaining a file of signed Nurse Practitioner Collaboration and Physician Assistant Supervision Agreements.
c) Tracking and monitoring collaboration/ supervision relationships to ensure that current statuses are known and accounted for. This process usually involves creating and maintaining a matrix to document and monitor the relationships. Such a matrix allows the program

manager to ensure that each physician collaborator/supervisor does not exceed the designated number of individual APP full time equivalents (FTEs) collaborated with or supervised and to readily track APP and physician collaborators/supervisor comings and goings. This latter element requires reliable connectivity with operational elements in the organization so that the information can be adjusted on a real-time basis.

d) Collaborating with designated provider leadership to identify and approach potential physician collaborators/supervisors and to receive assistance with assuring compliance with APP collaboration/supervision agreement requirements, including chart reviews.

e) Ensuring the required chart reviews are received prior to submitting payroll processing for physicians who receive APP collaboration/supervision stipends.

f) Forwarding required chart reviews to the pertinent quality and credentialing/privileging entities within the organization.

The physician collaborator/supervision assignment process involves several sequential steps that utilize collaboration with pertinent provider leadership, from initially identifying appropriate and willing specialty-specific or scope of practice-specific potential collaborators/supervisors, to ensuring the corresponding APP collaboration/supervision agreements are completed, to verifying that all state-required forms are completed and submitted. A separate responsibility within this realm is ensuring periodic review of the APP collaboration/supervision agreements to ensure ongoing state regulatory compliance and organizational programmatic pertinence.

Although some states specify the number of APPs that can be overseen by any given physician, others do not. Organizations should determine a practical number of APP FTEs collaborated with and/or supervised based on the collaboration/supervision requirements, but not to exceed state parameters. Most organizations find that the maximum practical number of APPs to be collaborated with or supervised is 4 FTEs as long as the state permits that number.

Documentation submission/retention requirements include expectations of formal chart review, documentation of the reviews, submission of the reviews in a timely fashion, and retention of the reviews. These expectations should be explicitly defined or referenced in the APP collaboration/supervision agreement. Creating and distributing a standard electronic or hard copy chart review form facilitates this process tremendously.

2. **Ensure that the APP collaboration/supervision agreements meet state requirements while explicitly outlining the organization's program and expectations.** Many states indicate that quality-of-care reviews and written protocols be in place, but often do not define specifics related to these requirements.

The most common form of quality-of-care review is the traditional chart review process. Charts should be randomly selected but represent the scope of services performed by the APP. Involving the APP in the chart selection process is usually perceived favorably, but it does present a potential double-edged sword. On the one hand, APP involvement permits the selection of cases that highlight specific questions or concerns, which is counterbalanced by the risk that the APP might "cherry-pick" charts with favorable documentation. Programs that advocate APP involvement in case selection promote the chart review process as a mentoring and learning opportunity, not as a "grading" process. This emphasis places the review process in a more favorable light and tends to actively involve both the APP and the reviewer in a more constructive process, thereby resulting in the intended educational outcome.

Explicitly defining the number of charts to be reviewed through either the APP Oversight Program policy or APP collaboration/supervision agreement—or preferably both—will unambiguously establish expectations for all involved. The numbers are usually based on a percentage of APP patient encounters for the interval in question (often monthly) with or without a maximum absolute number. Generally, at least 5-10 charts per month should be reviewed. Providing a standard review documentation form facilitates the process and ensures greater interrater reliability of the review process. The form on page 21 provides a sample chart review document.

In addition to involving the APP in the case selection process and utilizing a standard review form, the following additional points of emphasis and interaction tend to promote the chart review process in a positive light and minimize perceptions of solely being an unwelcome, onerous task:

- **Consider the reviews to be a mentoring opportunity.** This tends to elicit thoughts of a positive, mutually beneficial relationship that is more voluntarily accepted and often results in both parties looking forward to the interactions.
- **Schedule time each month.** "Finding time" is a primary complaint. Scheduling time on both schedules before or after patient care provides a "deadline" to keep the review process on track, but more importantly, it creates common expectations for discussing clinical care and professional development.
- **Capture "real-time" interactions.** Performing reviews of care in real-time during the actual patient encounter can save time and is often easier to capture than trying to recreate the situation and provide feedback after time has passed. Having forms at the ready facilitates these opportunities.
- **Regularly emphasize additional benefits.** Formal care reviews can enhance physicians' professional relationships with APPs, instill confidence that patients are receiving high-quality care, and mitigate the risk of "negligent supervision" concerns.

Indicating that the APP's practice is defined by granted clinical privileges and organizational policy and procedure is usually adequate for developing "written protocols" for practice in most situations. However, as always, reference state-specific requirements to be sure that the regulations are adequately addressed in this manner. For instance, some states require the delineation of acceptable reference textbooks or guides.

3. **Establish a standardized approach to APP collaboration/supervision stipends.** We believe that the effort involved with fulfilling specific collaboration/supervision criteria, such as formal chart review, exceeds the standard professional practice of being available for patient care consultation. Establishing a policy that APP collaborators/supervisors will receive an additional stipend for complying with APP Oversight Program requirements emphasizes the importance of the effort and rewards the primary collaborators/supervisors for their effort. The following caveats apply:
    a) A written agreement needs to be in place that outlines expectations and payments, e.g., the APP collaboration/supervision agreement.
    b) Stipends need to be consistent with documented national or regional benchmarks, which are readily available and help define FMV parameters.
    c) Stipend payment should not be made until program requirements for the payment interval are fulfilled.

Stipends can either be flat—a given amount per APP FTE—or tiered, usually based on the level of APP productivity. The flat amount is more common, especially since many programs indicate a maximum number of charts to be reviewed. The tiered amount is intended to acknowledge that APPs with higher patient volumes tend to have more frequent interactions with their collaborators/supervisors and more charts for the collaborator/supervisor to review (if a percentage-based chart review process is utilized). This methodology recognizes collaborator/supervisor effort and does not reward them for APP expended effort (e.g., get credit for APP-generated wRVUs), which risks a Stark violation.

Adopting these suggested best practices for medical directorships and APP oversight will allow the development of fundamentally sound, sustainable, compliant programs that will avoid commonly experienced pitfalls.

1 Ludi, Inc. is a health care technology company that makes it easier for hospitals to pay physicians. Ludi's DocTime Suite automates the payment process for any type of physician arrangement from a signed contract to payment. Ludi is trusted by hundreds of hospitals nationwide to help them track, manage and audit payments to physicians. (www.ludiinc.com).

2 With DocTime, physicians can easily track their time worked through an intuitive mobile app, making it easier for them to get paid and gain full visibility into their payment history. On the backend, DocTime helps administrative teams by centralizing and streamlining their entire contract payment process by offering a single repository of contract information, automated calculations, built-in approval workflows, ample compliance safeguards, and flexible reporting for handoffs to AP/Payroll.

APP Chart Review Documentation

Review Time Frame (month, year) _____

Medical Record Identifier					
Date of Service					

HPI, ROS, PMH appropriate for Chief Complaint					
Physical exam appropriate for Chief Complaint					
Differential diagnoses appropriate for evaluation					
Lab evaluation appropriate for diagnosis/ differential					
Imaging evaluation appropriate for diagnosis/ differential					
Treatment appropriate for diagnosis/ differential					
Follow up and other elements of Plan of Care appropriate					
Specific Comments related to care rendered					
Suggestions to improve level of care rendered					

Authentication

_____
Date Discussed

_____
Name of Physician Reviewer

_____
Name of APP Reviewed

_____
Signature of Physician Reviewer

_____
Signature of APP Reviewed

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A Pivotal Moment for Health System Partnership

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2023 could be a turning point in financial performance for not-for-profit hospitals and health systems, one rating agency predicts—but can these organizations afford to go it alone? What to consider in evaluating opportunities for partnership and crafting the right deal.

Healthcare merger-and-acquisition (M&A) deal volume slumped to its second-lowest level since 2000 (see Exhibit 1). But while experts expect a slow start to M&A activity in 2023, partnerships among not-for-profit hospitals and health systems likely will be key to success.

As healthcare organizations navigate the financial aftermath of the pandemic, workforce shortages, and an inflationary environment, we'll likely see more hospital and health system deals out of necessity. 2022 was "one of the worst financial years on record" for hospitals, according to a Fitch ratings analyst, who expects "a very bumpy 2023" for hospitals and systems. Most not-for-profit health systems ended the year with depressed margins and will continue to face financial challenges stemming from high labor and supply chain costs through 2023, as well as uncertainty in the financial markets. It's a situation that S&P says could take years for hospitals to recover from, financially.

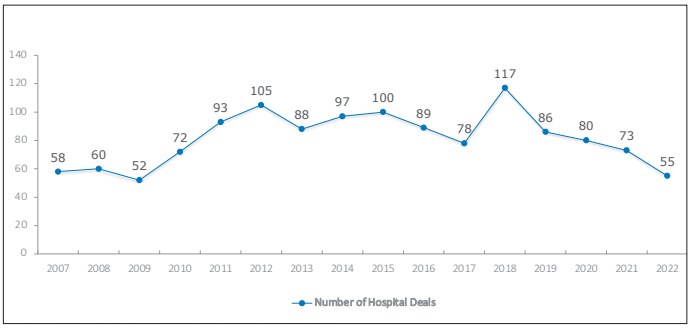

Exhibit 1. Trends in Hospital and Health System M&A

Source: Irving Levin Associates and AHA TrendWatch Chartbook and Modern Healthcare Transactions database.

In this environment, once again, not-for-profit hospitals and health systems must consider: Can we afford to go it alone? If not, how can we ensure that a *partnership*—whether in the form of a merger, acquisition or affiliation—is the right fit?

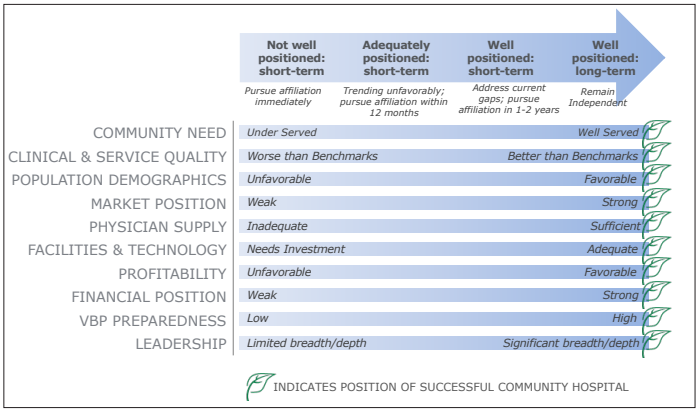

Exhibit 2. Assessing Your Hospital's Ability to Maintain Independence

The stakes are high. Larger organizations may have a path for getting performance back on track—but smaller, weaker organizations may not (see Exhibit 2). Organizations that are in a position to acquire another hospital or system will be much more rigorous in evaluating potential partners. And, the type of partnership model selected could significantly impact success. For instance, the looser the affiliation, the happier a formerly independent entity might be, but the lesser the financial benefit an organization could expect. Additionally, success involves more than what is seen on paper. It's also highly dependent on cultural fit.

Here are three major questions leaders and their advisers should consider.

What does our organization want?

Increasing financial pressures necessitate a proactive approach in determining not just whether an organization can remain independent, but also the benefits the hospital or health system should seek to gain from affiliation. These may include:

- **Access to capital**, which is crucial for material plant investments, growth-based strategies, technology and innovation—including digital innovation.
- **Clinical program development**, such as those geared toward target populations and conditions that affect a significant number of an organization's community and patients, and the ability to fill physician and care access gaps.
- **Access to economies of scale** and enhanced positioning in discussions with healthcare purchasers and vendors—providing a source of cost efficiency and improved margin performance.
- **Positioning for risk-based contracting**, including the ability to succeed in risk-baked arrangements, which requires access to population scale, specialized management expertise, a data analytics competency and infrastructure.
- **Improved geographic coverage and service mix**, helping to optimize market share—especially important as the payer market continues to consolidate and exert payment pressure.
- **Physician recruitment and retention capabilities**, especially at a time when well-funded physician aggregators, payers and retailers are aggressively competing for providers.
- **The ability to close gaps in senior-level knowledge due to resignations or retirements**, such as in areas like IT.
- **Bolstered liquidity position and reduced cost of capital**, vital to an organization's ability to weather the financial aftershocks of COVID-19 and inflation.

From there, organizations must prioritize the benefits that are most important to them. This will help focus discussions and negotiations with the potential partner organization.

It's not only important to understand what you want, however. You also need to know what you're bringing to the table. Understanding how your organization would stack up in the eyes of a potential partner is an essential part of this process, as it gives leaders a clear view of whether they can get what they need—and to what extent. Guiding considerations include the following:

- **Understand financial current and estimated future financial performance and position.** While nearly all hospitals and health systems are operating significantly below pre-pandemic levels, some are in a worse position than others. Ideally, starting the conversation around partnership should begin early, when the organization is still in a financial position sufficient to attract multiple potential partners. However, even if the financial picture is unfavorable today, being able to speak to a runway to financial stability and having concrete, quantifiable improvement initiatives underway will help a partner fully appreciate and understand the long-term value and risk profile of the partnership.
- **Size up the organization's capital needs.** Think about the capital requirements not just in the immediate aftermath of COVID-19, but also long term. For example, does the organization have the technological resources to provide remote care in the home for an aging senior population? Does it have the IT infrastructure to support data interoperability, which is delayed for now, but coming soon? Which capital projects should be fast-tracked to maintain market share, and which can be delayed—and for how long?
- **Gauge the organization's strategic weaknesses.** It's important to understand a hospital's areas of vulnerability as seen through a potential partner's eyes. For example, if the hospital's orthopedic group were to cut ties with the hospital to work with a competitor, where would that leave the organization in terms of elective surgery and diagnostic imaging revenue? What would it take to attract a new orthopedic group to your hospital—and how much of a capital infusion would be needed to support a return to service?
- **Contemplate what success would look like from a partner's point of view.** Success isn't solely defined by an organization's financial standing, but also by factors such as competitive positioning, market share, payment rates, and physician and patient satisfaction. For example, if your hospital were to lose two points in market share, how would this affect your balance sheet? If a new competitor were to enter the market, how would payer contracting rates be impacted? The key is to know the hospital's strengths and weaknesses at least as well as—and preferably better than—a potential partner.

When partnership is the desired approach, what type of partnership is the best fit? How attractive is this option to a potential partner?

Affiliations come in various forms, each with distinct advantages, disadvantages and considerations. It's important to consider the implications of each affiliation model to identify which forms might be optimal and—just as important—rule out any model that a healthcare organization is not willing to consider.

- **Determining the right model depends on the goals for affiliation**. There will be some aspects of an affiliation that the organization views as must-haves. Depending on the situation, these must-haves could be a subset of the benefits expected from an affiliation. For example, if an organization is highly leveraged, access to capital may be a requirement for any partnership. Must-haves do not need to be limited to benefits; they may also include cultural compatibility, assurances that current clinical services are maintained for the local community, or a guaranteed level of autonomy.

  Generally, the greater the desired financial impact, the greater the need to function as a single entity and the greater the financial risk borne by the partnering organization—which comes

with a proportionate loss of control to the partnering organization. Identifying the right balance of financial benefit and control is often one of the key tradeoffs for an organization seeking and evaluating potential partnerships.

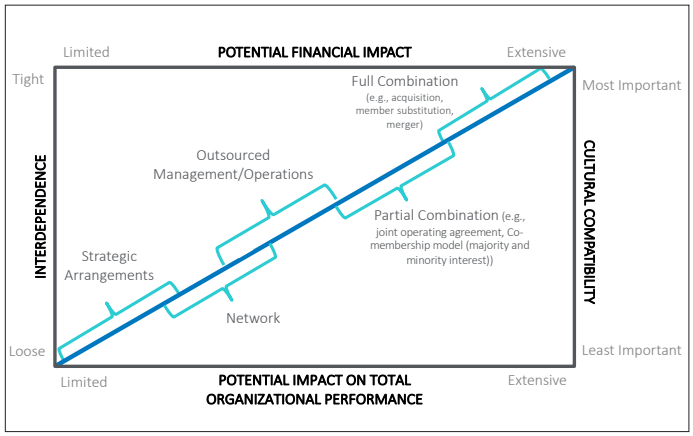

Exhibit 3. Understanding the Potential Implications of Affiliation Models

As shown in Exhibit 3, there are a range of partnership models, which traditionally include:

Strategic arrangements: Two or more organizations—even competitors—may collaborate to meet a clinical or business need together while remaining independent. Examples include targeted clinical affiliations between regional academic medical centers (AMCs) and community hospitals. Generally, financial impact is low for these types of affiliations. .

Network model: Formally (i.e., via a separate organization) centralizes various corporate services, such as purchasing, between organizations—typically in a common geographic area—to gain benefits of centralization and economies of scale through a collaborative network model without changing the ownership or governance of participants. Another version of a network model is networks focused on jointly pursuing population health and value/risk-based reimbursement strategies, like accountable care organizations and clinically integrated networks. While there is more potential for material financial benefit, the organizations are still independent and thus are not able to take advantage of many of the financial benefits of greater interdependence.

Outsourced management/operations: A contractual arrangement in which a healthcare provider organization agrees to manage another hospital without any change of control. This can be a springboard to tighter affiliation.

Long-term lease: This model is used when constraints on transfer of ownership hinder a more complete form of integration, often for district/municipally owned organizations.

Partial combination: Examples of partial combination or partial change of control models are described below. There is significant variation in the degree of financial impact and degree of retained independence afforded by these models, because each arrangement has its own flavor (e.g., majority vs. minority, reserved powers).

- **Joint ventures**: These are shared equity ownership arrangements and thus relevant to for-profit organizations and subsidiaries. As such, this structure is not a common model for the horizontal hospital and health system M&A universe. However, hospitals and health systems often pursue joint ventures for vertical areas of M&A activity, such as in the ambulatory surgery center space, with hospitals often sharing ownership in for-profit ambulatory surgery centers with surgeons.
- **Co-membership arrangements**: These partnerships are the not-for-profit version of a joint venture, with customized governance provisions that are unique to the transaction. A recent example of a majority interest co-membership arrangement took place in 2021, when Atlantic Health System became the majority (51%) member of CentraState Healthcare System via a comembership agreement.
- **Joint operating agreements (JOA):** Sometimes called a "virtual merger," under these agreements, effectively only the profit and loss statement is merged, while balance sheets remain separate. The degree of separateness inherent in this structure, however, makes governance, strategy, and capital finances difficult to coordinate, manage, and prioritize, which has led to mixed results with this model.

Full combination: Full combination models carry the largest potential financial impact, as the organizations begin to operate as a single entity, allowing access to the full scale benefits of affiliation. Examples of full combination models include:

- **Corporate member substitution:** Under this approach, typically the larger hospital or system assumes responsibility for the smaller hospital's balance sheet and becomes its sole corporate member. The system then has the authority to appoint the board for the previously independent hospital as well as certain key reserved powers. While there is no "purchase price" in this type of arrangement, financial commitments are often made, leading to strategic and operational integration. This option has the greatest appeal to boards that remain committed to retaining not-for-profit status for philosophical reasons and that wish to keep an active hand in the governance of the institution.
- **Merger:** In a merger consolidation, two organizations combine via the formation of a new, third organization. The new organization becomes the legal entity that replaces both separate entities. In the not-for-profit world, the new entity becomes the sole corporate member of both consolidating organizations.
- **Acquisition:** In an acquisition, the acquiring entity fully takes over the other party. The other party no longer retains a separate identity and becomes fully consolidated into the acquiring organization. Typically, a purchase price is paid to the seller. This model is the common full combination model for transactions involving for-profit selling entity(ies).

An organization's ability to influence the type of model depends on its attractiveness to a potential suitor. This is especially true at a time when dealmakers are likely to apply more rigorous scrutiny in evaluating candidates for partnership.

Who are the potential partners we should consider?

Being proactive in the affiliation process is essential. Organizations should not sit back and hope the optimal partner will seek them out to explore an affiliation. Leadership teams need to develop a list of potential partners from which they can initiate preliminary affiliation discussions. There are many considerations that can help refine this list:

- Are there organizations with which the hospital or health system has had beneficial partnerships in the past?
- Are there organizations that have been successful consolidators in the local or regional market?
- Is the hospital or health system willing to consider a for-profit partner? What about private equity?
- Are there organizations with which the organization believes it shares a common vision or compatible culture?

The first steps of a significant partnership process should ultimately be determined by the board, based on recommendations from the management team. The board should strive to reach consensus on as many of these considerations as possible. The answers to the questions noted above will ultimately drive the type of process that is adopted.

Hospitals may choose to negotiate with one or two preferred partners or embark on a more traditional M&A process involving the development of a request for an indication of interest and/or a more detailed proposal RFP) that will be sent to prospective partners. If and when this point is reached, the thoughtful and proactive consideration, analysis, and discussions about the organization's wants and needs that led up to this stage will serve your organization well when the time comes to evaluate the proposals received and select the best course of action.

Potential Affiliation Partner/Partnership Scorecard – Illustrative				
Criteria for Evaluating Partners	Potential Partner 1	Potential Partner 2	Potential Partner 3	Potential Partner 4
Culture	3	4	3	2
Partnership Experience – Track record in acquiring and integrating community hospitals	4	3	3	2
Preserved Autonomy – Does the partnership structure provide for desired degree of retained autonomy?	3	4	3	2
Financial Ability/desire to provide capital and payer contracting	3	4	2	1
Operations Support/integration of back office & IT	3	4	4	2
Clinical Support seamless, accessible continuum of care	3	4	4	2
Medical Staff Support development & Recruitment	5	5	3	3
Level of Interest	4	5	2	2
Ease of Integration – Are the barriers to integration relatively moderate or heavy?	2	5	2	1
Scale: 1 – Highly Unfavorable; 5 – Highly Favorable				

Exhibit 4. A Scorecard for Evaluating Prospects for Affiliation

You can't always get what you want … but you can get what you need.

Sometimes, the pressure to complete the deal can interfere with the need to make sure the relationship is being pursued for the right reasons. After all, not-for-profit hospital systems—especially independents—are more aware than ever of their weaknesses and vulnerabilities in a post-COVID world. But there are ways to protect the organization's interests for the long-term. Key actions include the following:

Conduct a financial gut check before moving forward with a deal. Developing a robust understanding of the financial implications of the partnership can, to an extent, be even more important than due diligence. Indeed, for boards, it is their fiduciary duty to understand the comprehensive impact of a transaction before moving forward. This consists of:

- **Quantifying financial and operating risks identified during due diligence—and understanding the future implications.** And assessing whether any findings suggest key deal terms need to be revisited prior to close.
- **Testing the impact of capital commitments.** Here, a *fairness opinion*—which assesses the reasonableness of the price for both parties and the terms of the transaction, including capital commitments—is essential. It will help, even force, leaders to determine: Are the areas of proposed investment appropriate, or should they be revisited?
- **Working with counterparts to identify post-transaction areas of opportunity.** This sets the foundation for realistic, tangible opportunities to be included in the prospective financials. While most synergies are not realized in the first year, there should be a list of low-hanging fruit opportunities that can be implemented in the first three to six months after the deal closes.
- **Pressure-testing assumptions.** This information will help manage risk and uncertainty more effectively.

Evaluate whether the deal is a fair deal. Here, it's important to consider: Can you identify the value the organization will receive from the transaction. A financially fair transaction does not have to represent the highest or best price. It should, however, represent a price that falls within the range of reasonable values identified. A formal fairness analysis should clearly identify and explain the valuation approaches used in the analysis with all supporting financial details. It should include a review and analysis of proposed terms of the deal; an explanation of the adjustments and reconciliations that were made in arriving at the valuation; and the sources of information used, including interviews with key hospital leaders and other constituents. It should also incorporate an analysis of the "value" of nonfinancial terms of the deal.

Don't forget culture fit. Just as chemistry between two individuals is one sign of whether a relationship is meant to be, connecting the similarities and differences between the mission, vision, and values of two healthcare organizations is crucial to determining whether the organizations are compatible for partnership.

When the organizations' purpose and aspirations are highly aligned, the potential for seamless integration increases—and that's good for patients and employees. When stark differences exist, organizations could find that a match that looks good on paper doesn't translate to agreements around decision-making processes, communication approaches, or management styles. If these differences aren't resolved to mutual satisfaction, one or both partners could end up feeling as though they've made the wrong choice.

Taking the time to carefully evaluate the synergies that exist between the organization and a potential partner as well as the potential for long-term value—for the hospital or health system and those it serves—can mean the difference between a healthy, long-term commitment and a relationship that starts strong, but fizzles shortly after it has begun.

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