

2020 Health Care Financial Management

Resource Guide



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

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Introduction

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

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

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

Emphasizing Rural Healthcare

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

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

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

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

Opportunities for Affiliation and Consolidation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Physician–Hospital Alignment

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

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

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

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

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

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

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

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

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

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

Physician-to-Physician Affiliation

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

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

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

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

Physician-Investor Affiliation

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

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

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

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

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

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

1. Private equity deals may be deferred for a short period as PE firms address existing investments.
2. Private equity firms will be involved substantially in the healthcare market.
3. Due to the abundant options from which PE firms choose, they will be highly selective and only align with top-performing groups and consortiums.
4. Physician groups and related healthcare entity sellers to private equity may have to retain more ownership (i.e., a larger minority interest) and be willing to accept lower multiples on EBITDAC.
5. In general, PE organizations will be aggressive, selective, and still subscribe to significant return on investment (ROI), placing pressure on the physicians to perform.
6. Physician groups will be challenged to convince their partners to pursue a PE transaction. No one will want the compensation reductions that result from PE deals, given the significant loss of income in 2020.

Valuation and Compensation Ramifications

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

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

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

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

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

Conclusions

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

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

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

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

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

Endnotes

- 1 Susan Morse, *Telehealth to become permanent under Trump executive order*, HEALTHCARE FINANCE (Aug. 3, 2020), <https://www.healthcarefinancenews.com/news/telehealth-become-permanent-under-trump-executive-order>.
- 2 Rural Health Information Hub, *Rural Hospitals*, (last reviewed Mar. 31, 2020), <https://www.ruralhealthinfo.org/topics/hospitals> (last visited Aug. 20, 2020).
- 3 Dhruv Khullar, *The Corona Virus Pandemic's Wider Health-care Crisis*, THE NEW YORKER (June 29, 2020), <https://www.newyorker.com/science/medical-dispatch/the-coronavirus-pandemics-wider-health-care-crisis> (last visited Aug. 20, 2020).



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How Much is Your Data Worth?

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Data is an Increasing Part of Healthcare Transactions

Healthcare data is being captured and utilized in an expanding range of applications and by a growing number of businesses. The volume and sources of these data are themselves expanding at a dramatic rate. According to RBC Capital Markets, data in the healthcare industry will grow at a 36 percent compound annual growth rate between 2018 to 2025, higher than in any other industry.¹ As data in healthcare continues to grow, the sharing and selling of data is critical to the success of certain businesses. As testament to the value of this data, in July 2020, Sema4, a patient-centered health analytics company based in Stamford, Connecticut, raised \$121 million in a Series C funding round at a post-money valuation of over \$1 billion.² Sema4 exemplifies how new computing techniques such as machine learning and Artificial Intelligence are being applied to very large data sets to enable a wide range of applications from identifying potential therapeutic leads, to detecting disease presence and stage in medical images, to determining the best, most precisely targeted treatments for a given patient. Improved technologies have driven the demand for bigger and broader data sets, and aside from numerous startups, major players include Amazon, Apple, Google, and IBM.

The data upon which these new applications rely has become critical to many businesses and as such, for healthcare entities that own these data, a valuable resource that can potentially be monetized. As a result, we see an increasing number of transactions that involve data, data-based analyses, and related products and services. When CNBC spoke with hospital executives in late 2019, many of them indicated they were receiving inquiries “all the time,” sometimes once a day or more, from companies seeking access to patient health information through licensing arrangements or partnerships.³ Critical to successfully negotiating these transactions is to determine a well-supported value and to appropriately price the data and services being transacted. Aside from the strategic question of how much the data is worth or what a company is willing to pay to obtain the data, a formal valuation may be critical to ensuring compliance with healthcare regulations that govern the payments in these transactions. For compliance purposes, pricing can be supported in part through a robust analysis of the Fair Market Value (FMV) of the data and data-related products and services exchanged in these transactions.

These transactions encompass a wide range in the types of data and data-related services involved; examples include:⁴

- » Demographics and socioeconomic data, e.g., age, gender, ethnicity, education
- » Health status data, e.g., morbidity, disability, diagnoses, signs & symptoms, behavioral data, risk factor data
- » Health resources data, e.g., provider, plan, or health system characteristics
- » Healthcare utilization data, e.g., nature and characteristics of medical care visits, procedures, treatments, prescriptions, adherence/compliance, and other elements of health encounters
- » Healthcare financing and expenditure data, e.g., costs, prices, charges, payments, insurance status, source of payment
- » Healthcare outcomes, e.g., health status and other outcomes of prior or current prevention, treatment, and other interventions over time
- » Genomic and proteomic data, tissue samples, pathology results

Given the diverse types of data and services transacted, it is not surprising that we see a wide range of deal structures. In a license arrangement, the transaction gives the licensee rights to healthcare data for specific purposes, such as identifying drug candidates, developing diagnostics, and identifying optimal treatment alternatives within specified fields of use. Key valuation issues are likely to include determining an appropriate royalty rate and/or milestone payments to the licensor, projecting revenues and/or profits, and estimating the probability of reaching relevant developmental and regulatory milestones and achieving commercial launch. In a co-development or joint venture (JV) type arrangement, data, analytics, intellectual property (IP), and/or services may be provided to a partnership in exchange for payments and an equity share. Key valuation issues include the value of each of the elements contributed to the JV by each party, and the value of consideration received by each party. This may include valuing data, IP, and services; projecting the JV’s development costs and risks; developing revenue and profit projections; and valuing the total equity of the JV and the share of equity to each owner based on the JV’s capital structure.

The COVID-19 pandemic has created new demands for data to better understand disease incidence; analyze the effectiveness of alternative prevention, diagnosis, treatment, and vaccination strategies; and determine various economic and financial challenges faced by hospitals, insurers, manufacturers, and service providers. At the same time, the methods for valuing these data, discussed further below, often rely upon industry data and market forecasts. Projections have become significantly more difficult given unprecedented conditions in a post-COVID-19 world, and valuation methods need to be tailored to properly consider current risks and potentially wide-ranging future scenarios.

Regulatory Compliance Considerations for Data Transactions

Participants in the healthcare industry receive scrutiny from regulatory agencies under anti-kickback, fraud and abuse, and pricing regulations, whether they are a healthcare provider, an insurer, a manufacturer, an information technology provider, or other actor. The federal government continues to aggressively pursue healthcare fraud and abuse with over \$2 billion annually in judgments and settlements won or negotiated in recent years.⁵ Transactions may be reviewed and/or challenged by the Department of Health and Human Services Office of Inspector General, the U.S. Department of Justice, the Internal Revenue Service, and the Centers for Medicare & Medicaid Services, as well as by state agencies. In addition to civil penalties, regulators often pursue criminal charges against individuals.

In any transaction that involves patient data, protection of data privacy is a paramount consideration. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established national standards to protect individuals' medical records and applies to health plans, health care clearinghouses, and health care providers that conduct certain health care transactions electronically. When exchange of patient healthcare data is part of a transaction being reviewed by the government, there may often be both data privacy and anti-kickback issues involved.

Federal and state statutes govern the pricing that is considered appropriate in deals that involve transfers of businesses, or business assets such as data. Included in these provisions is the requirement that healthcare entities may not pay or receive more than FMV for the assets or services exchanged. Additionally, certain payments tied to patient volume or referrals are construed as inappropriate inducements that are not allowed. Tax-exempt entities face additional considerations to ensure that a contemplated transaction does not result in private inurement.

Recently, new rules governing health data transfer and information blocking have created another area in which FMV considerations are relevant. In March 2020, the Department of Health and Human Services finalized the Office of National Coordinator for Health Information Technology's (ONC) interoperability rule, with an aim to facilitate patient access to, and ability to share, their electronic health information and enable more coordinated care among different healthcare and/or information providers. The new rules address information blocking: the intentional withholding of patient health information, either from one provider to another, or from a provider

to a patient. Among eight specified situations that provide an exception to being considered information blocking, one "enables actors to charge fees related to the development of technologies and provision of services that enhance interoperability, while not protecting rent-seeking, opportunistic fees, and exclusionary practices that interfere with access, exchange, or use of EHI."⁶ Provided certain conditions are met, it will not be considered information blocking if a fee is charged based on objective and verifiable criteria, such as the cost and a "reasonable" profit margin to provide access, exchange, or use of electronic health information.

Although the complexity and materiality of a transaction may drive the depth of analysis and documentation that is appropriate, it is highly advised to address the FMV of any transaction in which relevant compliance issues may apply.

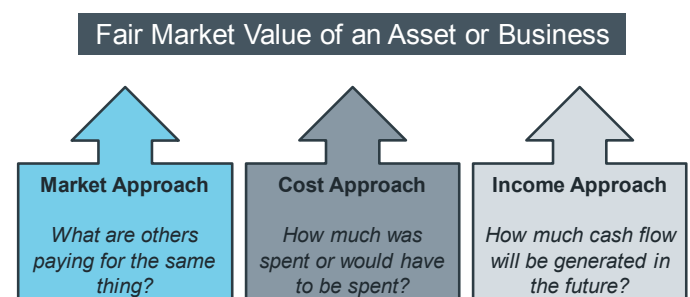
What is Fair Market Value and How Can It Be Estimated?

Fair Market Value is defined as the price that property would change hands between a willing buyer and a willing seller, neither being under any compulsion to buy or sell, and both having reasonable knowledge of relevant facts.⁷

Court decisions frequently state that the hypothetical buyer and seller are assumed to be able and willing to trade and be informed about the property and the market for such property. Further, the highest price a willing buyer would pay is also the price that a willing seller would accept.⁸ Additionally, for healthcare transactions, FMV means the price that an asset would bring as a result of bona fide bargaining between well informed buyers and sellers who are not otherwise in a position to generate business for the other and does not vary with, or take into account in any way, the referral or potential referral of patients or any other health care business between the parties for purposes of compliance with the Anti-Kickback Statute (42 U.S.C. § 1320a-7b), the Stark Law (42 U.S.C. § 1395nn), and the Stark regulations (42 C.F.R. 411.351).

Prior to negotiating and closing a deal, a robust valuation supports the pricing of the transaction and helps ensure regulatory compliance during post-deal execution. So how might one value such a transaction? As shown in the Figure 1 below, a Market Approach, Cost Approach, and/or Income Approach can support the concluded FMV of an asset or business.

Figure 1. Approaches to Determining Fair Market Value



Market Approach

Ideally, one looks for the prices that others are paying for similar transactions in an arm's length arrangements. In applying this "Market Approach," one seeks to find transactions that are as comparable as possible to the transaction being reviewed. This is fairly straightforward when estimating the FMV of a relative commodity such as bags of saline solution or four hours of medical chart coding. When valuing something less commoditized, we need to apply well-supported adjustments to the pricing of transactions that are as close to comparable as possible. Business deals are typically complex transactions that involve multiple deliverables and several pricing components and contingencies, making it difficult at best to find comparable publicly reported arm's length deals.

In addition to examining market value based on comparable data transactions, we can estimate the value of data based on the value of a company that holds the data. Assuming that company's primary asset is the data that it holds, the value of a patient record is simply the value of the company divided by the number of patient records. For example, when Flatiron Health was sold for \$1.9 billion to Roche in 2018, its 2.2 million research-ready patient records could be viewed as having an implied value of almost \$1,000 per record.⁹ The value of a data-rich company can be readily estimated for publicly traded companies based on their current stock price and filings. We can also rely on the implied company value in transactions where sufficient information is revealed publicly, as in the Flatiron example just mentioned.

A practical challenge with this approach is that a company is rarely just a data repository, and therefore, our analysis must address other assets, services, and products that contribute to the company's total enterprise value. In short, we need to carve out the portion of company value associated with its data from the portion of company value associated with everything else that contributes to its total enterprise value, which is not an easy exercise.

Finally, when reconciling different valuations implied by comparable transactions considered under the Market Approach, we must account for—and possibly make explicit adjustment for—key characteristics of a given data asset that affect its value. For example, data transactions often involve the purchase of raw or unstructured data from a health care provider by a data aggregator. The data aggregator may then process, clean, structure and combine raw data from multiple sources, steps that add value to the data set. The companies that perform this aggregation and sell these data to other third parties may be companies whose overall value we can see via their publicly traded stock prices or public transactions. The added value these companies are creating can be viewed as the increment between the value of the "raw" data transactions and the value of the company based on aggregated and clean data.

In summary, when we apply the Market Approach to value a particular data set of interest, we need to compare the specific characteristics of that subject data set to those of comparable companies and transactions, make appropriate adjustments to indicated prices, and determine where within a range of indicated values the FMV of the subject data set should fall.

Cost Approach

Given the practical challenges in applying the Market Approach, the "Cost Approach"—which values an asset based on what has been spent to create it or how much it would cost to re-create it—is sometimes considered. Here too, challenges exist. It may be difficult to identify relevant historical costs or to estimate the replacement cost. More importantly, the value of an asset may be substantially greater than the cost to create it, due to strategic value that goes above and beyond the asset's cost. For example, the cost that has been incurred by a health-care entity to collect and warehouse data may be small in relation to its value in the hands of a startup company using it to create new products and services, particularly if that data is based on a unique sample of patients or cannot be obtained through another source.

Income Approach

A third approach, the "Income Approach," overcomes many of the challenges we have mentioned by valuing the asset, service, or company based on projected incremental cash flow. A discounted cash flow (DCF) estimates the present value of this cash flow by applying a discount rate that a market participant would consider appropriate given the riskiness and timing of the cash flow. When there is significant uncertainty surrounding future cash flow, for example, the impact of COVID-19, multiple scenarios may be considered. Cash flows associated with each scenario are weighted by the corresponding likelihoods of the scenarios. The FMV pricing of the transaction would then be based on the resulting expected, or probability-weighted, DCF of the acquired asset or business. If the transaction consideration involves multiple components (e.g., an up-front payment and milestones tied to post-deal performance) then the analysis will consider the FMV of the transaction consideration as well as the FMV of the acquired asset or business.

The Income Approach is not without its own set of challenges. The valuation is sensitive to the cash flow projections and other inputs (e.g., discount rate, taxes, and long-term growth). As such, the assumptions behind these elements need to be well-supported. Additionally, in structuring payments and developing the corresponding cash flow projections, we must be cognizant of regulations governing payments that are tied to volumes or referral inducements.

Relief from Royalty Method

While a DCF values a business or asset based on projected incremental cash flow, the Relief from Royalty Method is a variation of the Income Approach specifically focused on valuing intangible assets including data and other IP. In the Relief from Royalty Method, the FMV of an asset is estimated by the present value of the royalties avoided because the company owns the intangible asset. The appropriate royalty rate is hypothetical. To determine an appropriate royalty rate, we employ a Market Approach by examining royalty-based transactions in which comparable data or IP has been licensed, making appropriate adjustments for differences in aspects such as fields of use, geographic coverage, and stage of development. Applying this estimated royalty rate to projections of the revenue or profit to which it would apply, we can estimate the stream of royalty that the IP owner would have to pay if they did not own the IP. The FMV

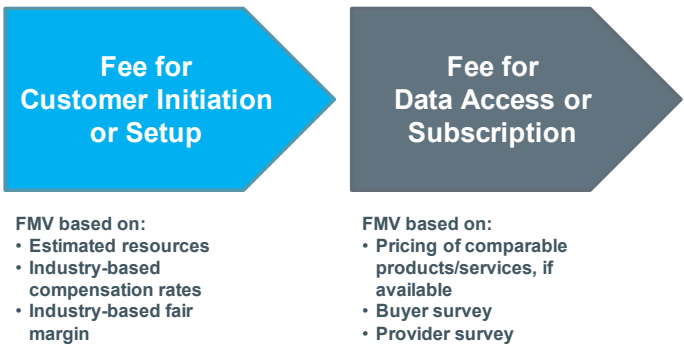
of the IP is then the avoided royalties, present-valued at a discount rate that reflects the risk and timeframe of the implied royalty stream. The challenges in implementing the Relief from Royalty Method mirror those of the Income Approach and Market Approach—namely, developing credible projections and identifying and adjusting comparable transactions.

How Can the Value of Data be Determined?

Estimating the FMV of data is often challenging due to the uniqueness of a given data set and the variety of data-driven products and services that may be associated with a data set. We will describe an approach we have used to value a variety of data products from one such provider, followed by two case study examples.

Contracts for data services often include an initiation charge or setup fee for the work of tailoring a data set or product offering to a customer’s needs, along with an annual subscription-type fee for the data or product itself. The FMV of the setup fee can be estimated using a Cost Approach, as the uniqueness of a given data set implies that unique activities and/or levels of resources are needed to create it. A Cost Approach is preferred as finding market prices for comparable setup activities is likely not possible given how customized these activities are to each situation. The fee charged for ongoing access to the data is addressed via a Market Approach as we will describe later.

Figure 2. Typical Pricing Structure for a Data Contract



Initiation Charge or Setup Fee

In applying the Cost Approach to estimate the FMV of the setup fee, if the organization has captured historical information, we consider the average and range of resources it has incurred for such activities; for example, the per-customer cost for the activities required in the past to on-board similar customers. This can inform projections of the resources that would be needed to on-board a given customer. The resource estimates are typically a range of hours by job title and reflect the variability across customers to on-board them for a given service; for example, based on the complexity of the required dataset, whether multiple data sources need to be integrated, the number of organizational touchpoints involved, and other factors. Facts and circumstances should be carefully considered when there is a need to allocate the resources on a per-dataset or per-product basis for activities that support multiple products or customers.

The total cost for setup is based on the required resources and the fully loaded salary of each resource as supported by industry compensation benchmarks. Finally, a fair margin is applied to the total cost based on the observed margins of comparable public companies.

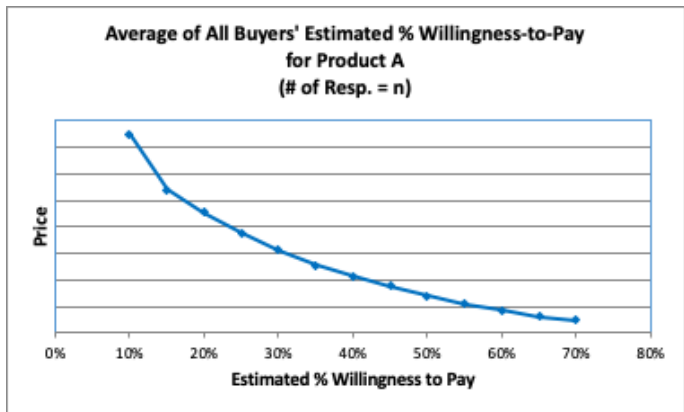
Fee Charged for Data Access or Subscription

Turning to the FMV analysis of the data itself, a Market Approach is typically used. If similar data products are available from several providers, the FMV of the data can be supported by the prices others charge for comparable products. However, the prices charged by other data providers are often confidential, or their products are not similar enough to be considered comparable. To support the FMV analysis it is helpful to research comparable data products, possibly through a customized survey of providers, to understand distinctions among their product offerings, gain at least a qualitative understanding of their pricing, and document how these findings corroborate a concluded FMV.

In the likely case that prices for comparable products are not available, information from a customized survey of “data buyers” can support application of the Market Approach by measuring buyers’ likelihood to purchase, depending on price and other characteristics. We have designed and fielded a number of such surveys, focusing on various types of products and services and their corresponding targeted buyer segments. The survey can present buyers with hypothetical datasets and product offerings that vary in the types of data, geographic/patient/specialty coverage of the datasets, frequency of updates, and other characteristics that differentiate products and providers.

From their responses, the “willingness-to-pay” of each buyer for various products is estimated. Willingness-to-pay is a measure of the likelihood that a buyer will purchase a data product at a given price, and it reflects both how well the product meets the buyer’s needs and other alternatives the buyer may have, either through another data product or provider, or by addressing the need internally or through other means. The final step is to estimate the FMV for each product based on a willingness-to-pay estimate for the market that is aggregated across survey respondents. The FMV for a given product is based on the price at which a specified percentage of buyers would be willing to pay for the service.

Figure 3. Estimated Willingness-to-Pay for Product A



The combination of a Cost Approach for the setup fee and a survey-based Market Approach for the access fee provides solid support for the indicated FMV of unique data products. A more sophisticated survey approach, conjoint measurement, can be used to provide robust support for more granular FMV pricing of data products that vary along a wider and deeper spectrum of characteristics.

Case Study 1: Valuation of Data Provided in Exchange for Services

An academic medical center with a rich source of healthcare data entered into a transaction with a healthcare analytics company, in which access to data would be provided in exchange for data structuring to facilitate research applications, de-identification to ensure patient privacy, data set cleansing, and receipt of software to enable medical center researchers and other staff to access the data. For compliance purposes, it was critical to ensure that the FMV of the data provided by the medical center was aligned with the FMV of the services received.

The value of providing access to de-identified data was estimated based on a Market Approach. Comparable publicly reported data transactions were identified. Based on the prices paid in these transactions and the sizes of the data sets involved, an implied price per patient record was estimated for each of these data sets. Although there are a large number of announced data transactions, financial details are rarely disclosed. The analysis was limited to only those transactions with sufficient details on pricing and other terms to support a conclusion as to the transaction's implied price per patient record, taking into consideration differences in characteristics of the various data sets.

For the data structuring, de-identification, and cleansing services, a Cost Approach was used. An estimated FMV for these services was based on the estimated resources required to perform them, considering the number and titles of required staff, hours per staff, and industry compensation data. The estimated FMV includes a fair margin on cost based on industry benchmarks. The FMV of the software provided to the medical center was based on analysis of comparable commercially available software.

The FMV analysis provided robust, independent support for the medical center's review of the transaction's compliance with applicable regulations.

Case Study 2: Valuation of Data and Analytics Sold to Manufacturers

A national clinic network provides a unique source of data which it makes available, along with analytics and software tools, to drug and equipment manufacturers to enable them to track usage of their products and competing products and analyze associated healthcare outcomes. For compliance purposes, the data provider needed to ensure that its pricing is consistent with FMV.

To estimate the FMV of these data and related services, a survey-based approach was used involving two components: a buyer survey and a data provider survey. Each was highly customized to the segments of products and buyers relevant to the data services addressed.

In the buyer survey, decision makers for data purchases from drug and equipment companies that are current or potential buyers of

these types of data were interviewed. To measure their willingness-to-pay for various data products, the survey described hypothetical data products and asked each buyer to express prices that they would associate with specified levels of their likelihood to purchase. Aggregating the results across the sample of buyers provided a willingness-to-pay curve for each data product—that is, the percentage of buyers willing to pay a given price for that product. A concluded FMV range for each product was associated with a specified portion of the product's willingness-to-pay curve.

In the data provider survey, representatives from companies that sell comparable data products were interviewed. A key part of the survey was to understand the characteristics that differentiate each company's products from those of other companies. Additionally, some hypothetical scenarios for a customer's needs were described as a basis to discuss how each company might address that need with its product offering and price its product accordingly. The survey provided a better understanding of differences in products and pricing between data providers and corroborated the FMV range concluded from the buyer survey.

So, How Much is Your Data Worth?

With applications of healthcare data growing at a rate that implies a doubling of data use every two to three years, and with many startups and established companies seeking bigger and broader datasets, data has become more valuable than ever. Valuations are critical to establishing the right price in a transaction, whether for strategic purposes, compliance purposes, or both. In this article, we have highlighted valuation approaches and challenges when pursuing transactions involving data and data-related products and services. Since no two transactions are the same, facts and circumstances must be considered, and valuations must be tailored to the information available to support a robust conclusion. An experienced and independent third party can facilitate a valuation process that lends confidence and defensibility to decisions on how much your data is worth.

Endnotes

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- 8 *Estate of Newhouse v. Commissioner*, 94 TC 193 (1990), Footnote 23 at 233.
- 9 See *supra* note 3.

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Avoiding the “New Normal” Trap: Maintaining the Integrity of Fair Market Value and the Compliance Process Through the Pandemic

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The coronavirus (COVID-19) pandemic has required us to adapt quickly to changes such as wearing masks, social distancing, virtual learning, and working remotely. The healthcare industry is experiencing this same shift from what was “normal.” Physicians and health systems have had to ride the waves of what has been a sea change in the way healthcare gets done. Hospitals are having to plan for the surge of positive COVID-19 patients to their facilities, while simultaneously addressing physicians and other providers experiencing a reduction in patient volume. From the appearance of the first U.S. case of COVID-19 on January 20, 2020¹ to the announcement of a public health emergency and beyond, there have been various government support programs, regulatory waivers, and public health advisories.^{2,3} With all these changes, including federal and state waivers, it is important to understand that financial arrangements continue to be under regulatory scrutiny and carry the burden of having to be commercially reasonable.^{4,5}

Longstanding practices within healthcare compliance still apply in the face of COVID-19 and the existing waivers. The “new normal” that so many are talking about does not signify a moment to deviate from the analytical process, otherwise such deviation may place the health system at immense compliance risk. Considering COVID-19, there are a number of valuation scenarios that are repeatedly confronting compliance officers, health lawyers, and health systems as they rise to meet the challenges brought on by the pandemic. This article examines several prototypical cases to illustrate how to think through fair market value (FMV) in the context of COVID-19, federal/state waivers, and the changing healthcare delivery landscape. The cases include (1) valuing physician base compensation in the context of reduced production volume, (2) evaluating the compensation structure of hospital-based coverage agreements, (3) providing a potential undue benefit through deploying hospital-employed advanced practice providers (APPs), (4) evaluating the inputs when performing healthcare entity valuations, and (5) ensuring medical timeshare leases are not overpriced.

Case Analysis 1 – Base Guarantee Compensation: When and How to Support Compensation in the Context of COVID-19

Dr. Smith is a general surgeon employed by a health system with a base guarantee. His production has been negatively impacted by COVID-19 through the system’s decision to stop elective surgeries to maintain critical supplies and bed capacity for COVID-19 patients. Are there enough productivity and/or services that Dr. Smith is performing to support his base compensation?

Health systems across the country are confronted with this question and finding that the answer is: It depends. To get closer to an answer, compliance teams need to define the base compensation in terms of the requirements and/or services that are being performed by the physician. What services is Dr. Smith performing? Is he at increased risk of contracting COVID-19? Is he performing additional services within or outside of his primary care specialty?

In this analysis, we will lay out two strategies to address the above questions and remain compliant: (a) address COVID-19 related needs through physician re-deployment, and (b) modify compensation design to align the base guarantee with expected levels of production.

Address COVID-19 Related Needs Through Physician Re-deployment

Given the emerging needs surrounding the pandemic, some physicians experiencing a reduction in patient volume⁶ are being redeployed to provide COVID-19 related services for the health system. Re-deployment can occur in clinical, administrative, or other service areas. Table 1 on page 16 illustrates the typical services provided by a physician for their base guarantee.

Table 1: Components of value to derive base guarantee

Services / Requirements	Value
Clinical Services	A
Administrative Services	B
Call Coverage Services	C
Other Services	D
Total Base Compensation	A+B+C+D

Options to support the base compensation include accounting for hours worked toward clinical redeployment; re-aligning the value for services provided; and recruiting physicians for needed administrative services.

Clinical Redeployment

To provide the necessary coverage, physicians are being redeployed to staff urgent care clinics, telehealth services, and inpatient COVID-19 units. Anesthesiologists, orthopedists, and cardiologists are seeing the greatest demand for their services and as a result, are forming COVID-19 teams to care for the surge of patients.⁷ For example, Henry Ford Health System created a database of their 1,500 physicians illustrating each physician's training and skill set in order to determine who meets the guidelines to be able to provide ICU treatment versus general medical care.⁸ These hours should be used in support of the clinical services being provided by those physicians.

Re-alignment of value

Re-aligning value also may provide support through either assigning greater value to each hour worked or by shifting value from production to quality-based metrics. While many health systems have not compensated physicians for hazard pay, the value associated with the increased health risk to physicians exposed to COVID-19 may be considered as support for the base guarantee. This concept is not without precedent considering hazardous duty pay in other areas (environmental differential pay,⁹ imminent danger pay in the military,¹⁰ off-shore drilling compensation,¹¹ etc.). The adjustment to compensation typically ranges between 10% to 30% of base compensation.¹² Further, given the industry shift toward quality-based care, compliance teams may consider adding a greater proportion of value toward quality metrics for the physician. By shifting a portion of compensation to incentives based on clinical quality, patient service, and organizational citizenship, compliance teams can document value attributable to these metrics and thereby further identify support for a physician's compensation.

Administrative Support

Physicians can also serve vital administrative roles toward combating the pandemic. Health systems are finding an increased need for clinical expertise to be included on administrative teams. To determine administrative compensation, the specialty data used should match the skill set, expertise, and job requirements needed. In terms of comparables, administrative compensation survey data should be prioritized when possible over solely utilizing clinical compensation

surveys.¹³ Table 2 below demonstrates the importance of choosing the correct compensation level for the service given the difference between salaries reported from clinical compensation surveys versus medical directorship surveys.

Table 2: Clinical Compensation Surveys vs Medical Directorship Surveys

Survey Percentiles	25 th Percentile	50 th Percentile	75 th Percentile	90 th Percentile
Family Medicine Clinical Compensation ¹	\$108	\$127	\$153	\$188
Family Medicine Medical Director Compensation ²	\$125	\$127	\$150	\$150
Hourly Rate Discrepancy	\$17	(\$0)	(\$3)	(\$38)
Neurosurgery Clinical Compensation ¹	\$354	\$438	\$558	\$693
Neurosurgery Medical Director Compensation ²	\$265	\$300	\$300	\$359
Hourly Rate Discrepancy	(\$89)	(\$138)	(\$258)	(\$334)

¹ 2020 MGMA DataDive Provider Compensation and Production 2020 Survey. MGMA

² 2020 MGMA DataDive Medical Directorship Compensation Survey. MGMA

As seen in Table 2 above, the administrative hourly rates are lower across the majority of the percentiles when compared to the clinical survey data. The discrepancy widens proportionally as the clinical compensation increases with higher paid sub-specialists.

In summary, compliance teams should employ the following best practices when deriving the values to support the base guarantee:

- » Document all hours worked and identify value in any increased risk physicians are bearing under the pandemic.
- » Convert a portion of the base compensation to include quality metrics.
- » Review multiple surveys to ensure validity while minimizing the use of statistically insignificant data from small sample sizes.
- » Utilize the correct level of compensation from the surveys. Reported compensation in the surveys represents total compensation, including other earning streams (i.e. medical directorship, on-call coverage, graduate medical education (GME), sign-on bonuses, quality incentives, etc.). Therefore, when deriving a clinical only value, potential adjustments to the survey data need to be considered.
- » Evaluate total administrative hours for reasonability and determine the administrative hourly rate as a function of the total number of administrative hours worked.

Modify Compensation Design to Re-align the Base Guarantee to Expected Production Levels

For some physicians experiencing significantly less volume, redeployment may not be enough to support their base guarantee. As a result, health systems will need to adjust their compensation terms. The health system's compliance risk increases if the physician also receives various earning streams in addition to their base guarantee. Table 3 on page 17 illustrates this risk by comparing the compen-

sation metrics for a general surgeon at 8,000 wRVUs versus 5,000 wRVUs with a base guarantee of \$400,000 per year.

Table 3: Impact of production on base compensation			
Compensation Category	High Production Volume at 8,000 wRVUs	Low Production Volume at 5,000 wRVUs	Value
Base Guarantee	\$400,000 per year	\$400,000 per year	A
Call Coverage	\$ 90,000 per year	\$ 90,000 per year	B
Medical Direction / Administrative	\$ 35,000 per year	\$ 35,000 per year	C
GME Didactic / Other Services	\$ 10,000 per year	\$ 10,000 per year	D
Total Physician Compensation	\$535,000 per year	\$535,000 per year	A+B+C+D
MGMA Benchmarking & Ratio Analysis			
Total Compensation per wRVU	\$66.88 per Wrvu (50th Percentile)	\$107.00 per wRVU (> 90th Percentile)	

As can be seen through this analysis, the total compensation can vary significantly in terms of the effective compensation to wRVU ratio. Under the reduced volume and the unadjusted base guarantee, the effective compensation to wRVU ratio is \$107 which benchmarks at 102% of the 90th percentile. Given production at the 25th percentile, maintaining the physician's base compensation at this level would increase the system's compliance risk. Some of the steps that can be taken to mitigate the risk are as follows:

- » Reduce the base to a level consistent with clinical production.
- » Require some or all of the earning streams (on-call, administrative, and APP supervision services) to be compensated under the base guarantee.
- » Continue with current base under the assumption that production volume is expected to return to prior levels and any deficit would be reconciled at year end or upon early termination.
- » Calculate the effective wRVU conversion rate and/or compensation to professional collection ratio to ensure that the base guarantee is not out of balance with the work requirements.

Physician compensation needs to be specific to each physician and his/her set of circumstances. As a result, compensation plans need to be responsive while proceeding through the pandemic.

Case Analysis 2 – When Hospital Inpatient Demand Goes Down: Structuring a Compliant Hospital-based Coverage Agreement

Anesthesiology Services, Inc. has an agreement with the health system for anesthesia coverage for six sites of service under a collections guarantee. Given reduction in elective procedures and non-COVID-19 services, the volume of professional services provided by the anesthesia group dropped by 50%. The health system is concerned about maintaining an agreement that is compliant.

Hospitals are currently reviewing professional services agreements (PSAs), like the one described above with Anesthesiology Services, Inc., to ensure that the health system remains compliant and financially viable given the impact on inpatient services from the pandemic. What is the compensation structure for the PSA? How does the structure translate into the health system's payment obligation? How do we account for relief fund packages, such as the Paycheck Protection Program (PPP), received by contractors and physician groups?

In this case analysis, we will discuss the analytical framework by which compliance teams can review their hospital-based PSAs and account for: (1) receipt of COVID-19 relief funding by contractors and (2) declines in patient volume.

Account for PPP and Other COVID-19 Relief Funds

Relief funds received by contractors and physician groups are meant to help cover the cost associated with their practice in light of the reduction in patient volumes due to the pandemic. While these funds are not professional collections, they do need to be accounted for, especially under a collections guarantee compensation structure. In this case, Anesthesiology Services, Inc. has received PPP funding to help cover payroll costs. The health system is reconciling the group's collections against the monthly collections guarantee. In doing so, it is critical for systems to include all PPP and other COVID-19 relief funds received in their reconciliation process. Otherwise, the health system may be paying more than appropriate to the contractor. Table 4 below illustrates the impact from excluding such funds from the reconciliation calculation.

Table 4: PPP and other COVID-19 relief funds under a collections guarantee				
Reconciliation		Collections Guarantee	Collections Guarantee with PPP / relief funds	Variance
Collections Guarantee	A	\$3,900,000	\$3,900,000	
Less: Professional Collections	B	(\$2,500,000)	(\$2,500,000)	
Less: PPP / Relief Funds	C	\$0	(\$500,000)	
Health System Payment to Contractor	A minus B minus C	\$1,400,000	\$900,000	\$500,000

Given the sample reconciliation statement above, the health system would save \$500,000 per year by correctly incorporating the relief funds into the collections guarantee reconciliation. If excluded, the health system's potential overpayment may result in a compliance and/or financial risk. As such, all collections received and used by the contractor toward the services provided under the PSA need to be included in the reconciliation process.

Establish a Maximum Stipend in the Context of a Collections Guarantee Structure

The benefit of the collections guarantee structure is that both parties share in the financial risk. However, the primary risk to the health system under this structure is when production volume declines. In this case, Anesthesiology Services, Inc. has experienced a 50% drop

in patient volume. Given this drop in volume and associated professional collections, the health system is potentially exposed to paying higher than expected compensation to the contractor. Table 5 below provides an illustration of this exposure by comparing the impact on the health system's contractual payment under current patient volumes with the payment at pre-pandemic levels.

Table 5: Potential financial risk under a collections guarantee				
Service-Line Income Statement		Pre-pandemic analysis	Pandemic Impact	Variance
Professional collections	A	\$2,500,000	\$1,500,000	(\$1,000,000)
Physician / APP compensation	B	(\$3,500,000)	(\$3,500,000)	\$0
Physician malpractice	C	(\$100,000)	(\$100,000)	\$0
Operating expenses	D	(\$300,000)	(\$300,000)	\$0
Net income/loss	G	(\$1,400,000)	(\$2,400,000)	(\$1,000,000)
Implied annual collections guarantee	Sum B+C+D+E+F	\$3,900,000	\$3,900,000	\$0
Implied annual stipend paid by health system	A minus G	\$1,400,000	\$2,400,000	\$1,000,000
Adjustment to Compensation Terms (Setting a Maximum Annual Stipend)				
Service-Line Income Statement		Pre-pandemic analysis	Pandemic Impact	Variance
Maximum Annual Stipend under PSA		\$1,700,000	\$1,700,000	
Implied annual stipend paid by health system		\$1,400,000	\$1,700,000	
Financial risk shifted to contractor		\$0	\$700,000	\$700,000

As can be seen, the annual collections guarantee remains \$3,900,000; however, the drop in patient volume has resulted in the anesthesia group collecting \$1,000,000 less as a result of the pandemic. Holding constant expenses, the health system will absorb this collections loss through their annual required payment. Under a collections guarantee compensation structure, the health system bears most of the risk associated with patient volume fluctuations. This risk can be mitigated by contractually setting a maximum stipend to be paid under the subject agreement. This adjustment to the compensation terms is shown in Table 5 above. For instance, if the maximum was set at \$1,700,000, then the health system would have saved \$700,000, instead of being obligated to pay the additional \$1,000,000.

Case Analysis 3 – Proceed With Caution When Deploying Hospital Employed APPs to Assist Contractors and Community Physicians

Hospitalist Services, Inc. has an agreement with the health system to cover the inpatient units under a stipend arrangement. Given the surge of COVID-19 patients, the volume of professional services provided by the hospitalist group has increased

by 75%. The group is concerned about caring for the increase in patient volume and believes it needs to add more staffing and compensation. Amid this surge in COVID-19 patients, the hospital decides to hire 3 APPs for the service to use while holding constant the current stipend.

APPs are increasing in number across the U.S. healthcare system and are commonly used within hospital-based specialties.¹⁴ The pandemic has resulted in increased regulatory flexibility surrounding the use of APPs in terms of supervision, reimbursement, and scope of practice.^{15,16} This flexibility has continued to fuel a not-so-uncommon practice for health systems to employ hospital-based APPs and place them within a hospital-based service line as members of the patient care team. This occurs in a wide range of specialties, including but not limited to hospitalist medicine, intensive care medicine, emergency medicine, obstetrics and gynecology, general/trauma surgery, radiology, and neonatology services.

In this case, APPs employed by the health system are material as it relates to the value of the subject agreement with Hospitalist Services, Inc.—this is a salient point that is often overlooked. If APPs are being used but are not employed by the contractor, the costs associated with them should not be a factor in either deriving the stipend or the collections guarantee. As Table 6 below illustrates, there is a significant difference (\$240,000 per year) to the subject agreement compensation depending on the APP costs factored into the model. This carries a potential compliance risk for providing an undue benefit to the hospitalist group.¹⁷

Table 6: APPs Employed by Health System: Calculating the Undue Benefit			
Income Statement	Hospitalist Service – APP Employed by Contractor	Hospitalist Service – APP Employed by Hospital	APP Value
Total Revenues	\$1,000,000	\$1,000,000	
Expenses:			
Physician Costs	\$1,200,000	\$1,200,000	
APP Costs	\$240,000	-	
Professional Liability	\$60,000	\$60,000	
Operating Expenses	\$126,000	\$126,000	
Total Expenses	\$1,626,000	\$1,386,000	
Implied Subsidy	\$626,000	\$386,000	\$240,000

From a billing perspective, the health system and the hospitalist group may be out of compliance if the group is receiving reimbursement for services provided by the APP under incident-to or shared/split visits rules. Regardless if all medical documentation requirements are met by the physician group, the fact that the APP is not employed or leased by the same entity as the hospitalist, may violate the billing guidance specific to Medicare payers.¹⁸ In addition, only the APP's employer may be reimbursed for their services. As a result, a case could potentially be made for falsely submitting claims for services partly performed by the hospital-employed APPs.

In order for hospital-employed APPs to help shoulder the burden of increased patient volumes associated with COVID-19, there are a few strategies and contractual arrangements that can be used:

- » Have the contractor, such as Hospitalist Services, Inc., employ the APPs directly and adjust their PSA compensation structure accordingly.
- » Hospital may lease APPs to the contractor at FMV rates for the services provided.
- » Split/Shared billing only done when APPs are within the same group as the physician.

Case Analysis 4 – Healthcare Transactions: Determining the Value of an Entity in an Altered Healthcare Landscape

A large primary care practice, ABC Family Care, is navigating the pandemic. However, they are experiencing a significant decline in volume and profitability. Given the current environment, they turn to the local health system to purchase their practice. The challenge for the compliance team is determining a value that appropriately factors in the impact from COVID-19, recognizes future stability in cash flows as the practice moves through the pandemic, and ensures that the transaction passes compliance scrutiny.

COVID-19 is fueling a change to the healthcare landscape that will result in increased acquisition activity with physician groups, home health agencies, and ambulatory surgery centers, to name a few.¹⁹ In this case, the physician owners of ABC Family Care are looking for a strategic alignment in order to increase stability and create opportunity for greater profitability. Given the consolidation in the healthcare space, business development teams at health systems across the nation will be under pressure to put forth competitive offers while maintaining compliance. As health systems look to acquire these entities for the purposes of growth, mission alignment, or vertical/horizontal integration, there will be increased scrutiny of these transactions in addition to the existing regulatory constraints. This is especially so given the large sums of healthcare relief funding provided by the government, coupled with the significant number of distressed healthcare entities. In a recent Federal Trade Commission (FTC) blog, Ian Conner with the Bureau of Competition alluded to preventing anti-competitive behavior by closely observing transactions in the context of the pandemic.²⁰ California has recently put forth Senate Bill 977 where parties would need to obtain regulatory approval prior to consummating the transaction.²¹ More states may follow the lead of the FTC and California. Given the potential for increased regulation, it is all the more important to ensure that established appraisal standards, outlined by industry associations like the American Society of Appraisers (ASA), National Association of Certified Valuation Analysts (NACVA), and American Institute of Certified Public Accountants (AICPA), dictate the approach to valuing the entity in light of COVID-19.

In this case analysis, we will review some of the critical elements that drive healthcare entity valuations as well as discuss appropriate methods and standards to be used in factoring in the effects of the pandemic on each. Decisions made regarding each of these elements have a material impact on the ultimate value derived from the analysis. To illustrate this point, we will focus on a few key areas:

(a) factoring in risk, (b) projecting reliable cash flows, (c) addressing the marketability of the entity, and (d) identifying comparable transactions.

Discount Rate: Factoring in the Risk

The components of the discount rate generally include (1) a risk-free rate, (2) an equity risk premium, (3) small company size premium, and (4) company-specific risk. On one hand, current interest rates on treasury bills are at historic lows, suggesting that the current risk-free rate of return in the market is significantly lower today than it was a few months ago. On the other hand, few would argue that there is less risk in the market today, so discount rates would tend to be higher. In order to fully account for current market conditions, it may be necessary to normalize both the risk-free rate and the equity risk premium as well as adjust the company-specific risk to capture the immediate and long-term effects of the pandemic in relation to the specific investment being valued. However, the valuation should take care not to undervalue the entity, such as ABC Family Care, by overstating the discount rate and understating the projected cash flows. This could potentially double count the risk.

Reliability of Cash Flows: A Call for Scenario Analyses

How reliable are ABC Primary Care cash flows? This is a critical question to answer when determining the value, not only for regulatory and FMV purposes, but also from a strategic and financial viability perspective. Given unemployment rates increasing and individuals losing their employer-based health insurance, will patients limit their visits to the doctor? How will providers continue to increase volumes while also taking steps to maximize the safety of their patients and staff? What impact will advances in telemedicine and their adoption have on the practice? Will these changes be for the short-term, medium-term, or long-term? Cash flows are one of the key drivers in the valuation under the income and market approaches. Performing various scenario analyses by varying recovery periods, and documenting the assumptions under each, will help provide the necessary support to ensure a value that is appropriate and applicable to the entity.

The Value of Liquidity: Discounts for Lack of Marketability

Applying pertinent premiums and/or discounts to the value remains a necessary adjustment to arrive at an accurate opinion. In the context of the pandemic, special attention should be made toward determining the potential discount for lack of marketability. Given the volatility in the markets along with the uncertainty in the course of the pandemic, the ability to liquidate the value of the business entity could potentially be impacted. If the pandemic causes an increase in mergers & acquisitions activity in the healthcare sector as some suggest, then a smaller discount may be warranted. On the other hand, if the pandemic causes delays in consummating those deals and it takes longer for the transaction to occur, then a larger discount may be appropriate. As a result, the application of a potential discount due to lack of marketability must be considered in the context of current market conditions.²²

Market Approach: Comparability is Critical

Valuators will need to nuance the market approach in the coming year as the multiples relied upon in the past may bear little resem-

blance under COVID-19 economic conditions. Comparability to the subject entity is critical to the validity of the market approach. This method looks at multiples derived from a measure of value (i.e. market value of invested capital (MVIC), earnings before interest, taxes, depreciation, and amortization (EBITDA), Price/Earnings). Comparing pre-COVID transaction data to post-COVID measures of value for the subject entity creates an inherent flaw in the resultant value. Despite this flaw, there may be some adjustments that can be made to this method to normalize for the economic impact from COVID-19. Perhaps looking at the relative change in market capitalization within the space may give insight into the adjustment that should be made to the multiple.

Business valuations going forward will vary depending upon the type of entities involved in the transaction. Hospitals that are financially viable will continue their acquisition activity only if it is critical to their strategic plan, while other less fortunate hospitals may be forced to merge or be acquired. Physician groups will be looking to merge and/or partner with private equity firms or health systems. The level of transaction activity as well as the impact from COVID-19 will be specific to the sector within the healthcare industry.

Case Analysis 5 – What Stark Waivers Don't Waive: Overpayment for Medical Office Timeshares Is Still Not Permissible

Dr. Jones' partner has just retired, leaving some additional space in his practice underutilized. To expand their service area in obstetrics/gynecology (OB/GYN), a health system enters into a medical office timeshare with Dr. Jones to place one of their employed OB/GYN physicians in Dr. Jones' office two (2) half days per week. Under the Stark waivers, timeshare arrangements are mentioned.

While medical office timeshares are mentioned, all timeshare arrangements are not equally covered by the blanket Stark waivers. Only those timeshare arrangements that fall below FMV for the lease of office space, equipment, and services apply under the blanket waiver.²³ As a result, while there is coverage on the lower end of FMV range, the health system still needs to concern itself with potentially paying Dr. Jones above FMV for the timeshare lease.

Given the current environment and the pressures to increase volumes for physicians and hospitals, the health system may be willing to pay higher rates than normal for the timeshare lease. Higher than normal does not necessarily mean above FMV; however, it is critical that the system understand the value drivers that determine the rate. To determine the reasonability of a rate, the compliance team will first need to identify the components and services within the lease arrangement.

Space

The space should be calculated from an architectural drawing defining the square footage utilized in the subject agreement. Common areas along with dedicated exclusive use areas need to be clearly demarcated in the analysis to ensure that the space utilization is calculated accurately. After the total square footage applicable to

the tenant is identified (exclusive use square feet plus allocated shared common area square feet), it is multiplied by the FMV full-service rental rate of the space. It is recommended that this rate be determined by a real estate appraiser and account for building operating expenses.

Furniture and Equipment

Similar to the space analysis, the furniture and equipment utilized within the common and dedicated exclusive use areas need to be included. This may constitute waiting room chairs, desks, tables, computer/office equipment, etc. Obtaining market comparables versus utilizing depreciation schedules will yield a more accurate assessment of value. In addition, the Stark Law has a provision that dictates the ability to include medical equipment under these arrangements depending on whether the equipment is shared or used exclusively.²⁴ Equipment cost paid for by the tenant can be excluded.

Services

There is variability in the specific services offered under these arrangements. These services may include telecommunication services, front desk receptionist duties, nursing staff assistance, medical and office supplies, cable television, magazines, water and coffee supplies, among others. The provision of a receptionist and nursing staff of the leasing practice is often overlooked. A physician tenant may not be able to provide their own front desk receptionist, relying on the medical office's receptionist to greet a patient, provide paperwork to the patient, and notify the nurse the patient has arrived. Excluding this cost has a material impact on the FMV timeshare rate and needs to be included to ensure compliance.

Short-term Use Premium

A major component often missing from the medical office timeshare value is a short-term use premium. In other industries, a premium is paid for the part-time use of space or services (i.e. conference room, executive office suite, rental car, hotel, equipment, etc.). Medical office timeshares are no exception; in fact, it is essential to ensuring compliance. This premium can be impacted by the number of tenant time slots leased, the landlord utilization risk, and current market comparable transactions.

Each component of a timeshare transaction should be evaluated and added together to guide health systems in determining the upper end of value. Should the lease rate exceed such an analysis, the arrangement will need to be adjusted accordingly.

Summary

While the cases discussed do not cover all of the newly emerging challenges, the cases do illuminate the analytical framework and valuation principles needed to assess financial arrangements and provide a defensible value. Understanding and employing time-tested valuation principles within the context of the COVID-19 pandemic will help ensure safe navigation through the financial and regulatory risk in the current environment. Although the environment may be changing, the approach toward determining value should not.

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Navigating Through Uncertain Times: Health Care Financial Management During a Time of Crisis

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Since the beginning of the coronavirus pandemic, we have been flooded with news and information that changes on a daily basis. In addition to worrying about their personal health and the health of their staff and communities, leadership of health care entities also must consider both the immediate and long-term operational and financial implications of this crisis to their organizations. From preparing for and responding to the immediate COVID-19 crisis, to addressing cash flow concerns, staffing needs, and procurement of necessary supplies and equipment, to anticipating and adapting to long-term changes in the health care industry, health care providers and administrators are certainly navigating tumultuous waters during this challenging time.

The Pandemic

The coronavirus, later identified as “COVID-19,” first emerged in China in December 2019 and began to spread to other countries by January 2020.¹ Cases began to emerge in the U.S. in February, and President Donald Trump declared a national state of emergency on March 13, 2020.² Subsequently, many state and local governments issued stay-at-home orders and other measures in an effort to contain the spread of the highly contagious virus. Hospitals were immediately faced with challenges, starting with procuring adequate personal protective equipment (PPE) to enable their staff and physicians to safely care for COVID-19 patients. Meanwhile, elective procedures were banned by many state and local officials in order to preserve PPE and keep hospital space available to treat the expected surge of COVID-19 patients. This created the combined effect of increasing operating costs while revenue plummeted. Furthermore, many of the delayed or canceled elective procedures are often the highest-margin activities in a hospital due to the way payer contracts have historically been negotiated. To compensate, many health systems furloughed non-essential staff (both clinical and administrative), while others chose to take other cost-cutting actions and delay capital projects.³

As administrators, providers, and health care investors cope with the challenges of managing their organizations through this crisis, they must focus on remaining financially strong so they can successfully emerge from the current turbulence and ensure continued access to care in the communities in which they operate. This article focuses on four primary areas impacting the financial management of health care organizations as they navigate the current uncertainty:

1. Funding and cash flow sources, primarily resulting from the CARES Act and subsequent legislation;
2. Provider revenue streams;
3. Physician compensation; and
4. After the crisis.

Funding and Cash Flow Opportunities

The Coronavirus Aid, Relief, and Economic Security Act (CARES Act) was enacted on March 27, 2020, in response to the sudden and severe economic impacts across the country from the pandemic and subsequent shutdowns and stay-at-home orders. Many of the CARES Act provisions relate directly to funding for the health care industry. Other provisions relate more broadly to small businesses, which include a number of physician practices and other health care entities. The CARES Act also included provisions giving health care providers increased flexibility to serve patients more effectively during the crisis—most notably, in the area of telehealth. Subsequent legislation was passed to increase funding for certain CARES Act programs, including the Paycheck Protection Program and Health Care Enhancement Act (PPP) enacted on April 24.

Provider Relief Fund

A total of \$175 billion was earmarked to reimburse eligible health care providers for health care related expenses or lost revenues attributable to coronavirus.

Approximately \$50 billion of the fund was tagged for “General Allocation,” and in order to get money to providers quickly due to the dire nature of the need, an initial \$30 billion distribution was made based on providers’ relative share of 2019 Medicare fee-for-service reimbursements. Subsequent communication from the Department of Health and Human Services (HHS), the agency responsible for overseeing the program, noted that the initial distribution was, in effect, an advance on the actual allocation that would be based on each eligible provider’s relative share of 2018 net patient revenue. For entities required to file CMS cost reports, this data was already available to HHS. However, many other health care providers do not file cost reports and instead were required to submit revenue information to HHS in order to be considered in the allocation of funds. On July 10, 2020, HHS announced that dental providers, who had previously been excluded from the program, were also eligible to apply for relief.

Other funds were allocated to specific uses, including:⁴

- » **High-Impact Allocation** (\$22 billion) – These funds were designated for areas most significantly impacted by the outbreak of COVID-19 cases. The initial round of \$12 billion was distributed to 395 hospitals, with over half going to providers in New York and New Jersey.⁵ On July 17, HHS announced a second round of \$10 billion to be distributed to hospitals with more than 161 COVID-19 admissions between January 1 and June 10, 2020, with payment of \$50,000 per admission.⁶ Any payments received in the first round of funding will be considered in the determination of eligibility for second round distributions.
- » **Rural Providers** (\$11 billion) – These funds were provided to rural acute care general hospitals, critical access hospitals, rural health clinics, and community health clinics located in rural areas. Texas received the highest distribution from this fund (\$634 million for a total of 393 providers).
- » **Skilled Nursing Facilities** (\$4.9 billion) – These funds were intended to enable nursing homes to provide quality care to seniors and keep them safe during the pandemic.
- » **Safety Net Hospitals and Acute Care Hospitals** (\$13 billion) – \$10 billion was distributed to safety net hospitals and \$3 billion was distributed to hospitals serving vulnerable populations.
- » **Testing and Treatment of Uninsured** – No specific funding amount was specified, but this portion of the fund will be used to reimburse providers for care provided to uninsured COVID-19 patients. Providers must submit claims through the program to receive reimbursement at Medicare rates, subject to availability of funds. To date, over \$82 million has been paid on claims for testing and over \$265 million has been paid on claims for treatment.

Hospital Inpatient Prospective Payment System Add-On Payment

During the emergency period, the weighting factor that would otherwise apply to the diagnosis-related group (DRG) to which a patient’s discharge is assigned is increased by 20% for Medicare patients

diagnosed with COVID-19. This provision was implemented in an effort to ensure that hospitals caring for COVID-19 Medicare patients are adequately reimbursed for such care, given the uncertainty surrounding length of stay and total cost of care for the diagnosis. State Medicaid agencies are authorized to make the same adjustment, even if they have received a 1115A waiver.

On July 25, 2020, HHS renewed its determination that a public health emergency exists.⁷ This renewal effectively extends the add-on payment for another 90 days, or until the public health emergency is either rescinded or extended.

Delay of Medicare Sequestration

Medicare sequestration was suspended from May 1, 2020 through December 31, 2020, resulting in a 2% increase in Medicare reimbursement on all claims for services provided during this period. However, sequestration will be extended through fiscal year 2030 (rather than expiring as scheduled in 2029) to recover those funds.

Paycheck Protection Program (PPP)

A total of \$659 billion has been appropriated for forgivable loans to small businesses, primarily for the purpose of paying their employees during the COVID-19 crisis. While the PPP was not an option for large hospitals and health systems, this program was available to qualifying physician practices, dental practices, and other smaller health care providers who also experienced significant disruptions to their normal patient volumes. Eligible entities were generally required to have fewer than 500 employees, and could borrow up to 2.5 times average monthly payroll costs, not to exceed \$10 million, and use the funds to pay payroll costs (including benefits), mortgage interest, rent, and utilities during a covered period following receipt of the loan. The covered period was initially established as eight weeks but was expanded to 24 weeks in the Payroll Protection Program Flexibility Act of 2020, enacted June 5. The expansion was considered by many small businesses to be necessary given the duration of stay-at-home orders and the inability of many businesses to resume normal operations within the timeline initially contemplated.

Loan amounts under this program are forgivable to the extent the number of employees during the covered period is maintained at historical levels, and salaries and wages for individual employees are not reduced by more than 25%. No more than 40% of the forgiven amounts may be for approved non-payroll related expenses.

As of this writing, PPP funds are still available. The original application deadline of June 30 was extended until August 8 to give small businesses more opportunity to avail themselves of this funding as they begin to re-open. Additionally, new legislation was proposed in the Senate on July 27 that seeks to allow eligible small businesses to access a “Second Draw” PPP loan, and adds several categories of eligible expenses. This legislation is likely to be heavily debated, and it is unclear at this point what the final outcome will be.

Medicare Accelerated / Advance Payment Program

Though not part of the CARES Act, CMS early in the crisis allowed Medicare Part A and Part B providers to request accelerated payments on a periodic or lump sum basis to provide needed liquidity.

Providers could request up to 100% (or up to 125% for critical access hospitals) for up to a 6-month period after the emergency declaration associated with COVID-19 (i.e., March 13, 2020). Eligible providers included inpatient acute care hospitals, children's hospitals, specialized cancer hospitals, critical access hospitals, and Part B providers such as ambulatory surgery centers, physicians, and durable medical equipment (DME) suppliers. After enactment of the CARES Act, CMS expanded the accelerated payment program to include all Medicare Part A and Part B providers and suppliers throughout the country who had billed Medicare for claims within 180 days prior to making the request for an advance, among other criteria.⁸ CMS stopped accepting new applications for the Advanced Payment Program on April 26, citing that providers have access to other funds through the Provider Relief Fund and other federal funding programs.

Hospitals that received advance payments have up to 120 days before claims start being offset against the advance to recoup the accelerated payments. The outstanding balance must be paid in full within twelve months of the date of the initial advance. Provider entities that accessed these funds are concerned that the repayment provisions as currently constructed will have an extremely detrimental impact on cash flow once current claims start being offset against the advances, in effect merely delaying the revenue decline from April/May to six months later.

Legislation has been introduced in Congress to address these concerns. Key changes to the program would include delay of any

recoupment for a full year, and capping recoupment at 25% of claims. It would also give providers two years to repay the advances and caps the interest rate at 1%.⁹ Concerned that legislation might not be enacted before current repayment provisions are scheduled to begin, key industry groups are urging CMS to delay repayments until after legislation is adopted.¹⁰

COVID-19 Telehealth Program

The CARES Act appropriated \$200 million to the Federal Communications Commission (FCC) to support health care providers' efforts to address the coronavirus pandemic by ramping up their use of telehealth. This program provides funding for costs related to telecommunications services, information services, and devices necessary to enable the provision of telehealth services during the emergency period. As a result of this authorization, the FCC established the COVID-19 Telehealth Program.

The Telehealth Program was open to eligible health care providers in both rural and non-rural areas, providing support for fund recipients to purchase telecommunications, information services, and connected devices to provide telehealth services on a temporary basis in response to the pandemic, whether directly for treatment of COVID-19 or for treatment of other conditions during the emergency period. Rewards under this program provide full funding for eligible services and devices, though awards to any single applicant were capped at \$1 million. Funding received from the Telehealth Program could be used for any necessary eligible services and connected devices.

COVID-19 CRISIS TIMELINE	
Dec 2019	Coronavirus emerges in China
21-Jan-20	1st coronavirus case confirmed in U.S.
3-Feb-20	U.S. Declares Public Health Emergency
1-Mar-20	CMS issues blanket Stark waivers
13-Mar-20	National State of Emergency declared by President Trump
17-Mar-20	CMS Expands Telehealth, relaxes restrictions
27-Mar-20	CARES Act becomes law
28-Mar-20	CMS expands Accelerated & Advanced Payment programs
24-Apr-20	PPP and Health Care Enhancement Act becomes law
26-Apr-20	CMS stopped taking new applications for AAP programs
1-Feb-20	Medicare Sequestration suspended through 12/31/2020
5-Jun-20	PPP Flexibility Act of 2020 becomes law
23-Jun-20	Hospital Price Transparency Rule upheld
25-Jul-20	HHS renews Public Health Emergency declaration

The Telehealth Program was limited to nonprofit and public health providers in the following categories:

- » Post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools;
- » Community health centers or health centers providing health care to migrants;
- » Local health departments or agencies;
- » Community mental health centers;
- » Not-for-profit hospitals;
- » Rural health clinics;
- » Skilled nursing facilities; or
- » A group of health care providers consisting of one or more entities falling into the previous categories.

On July 8, the FCC announced that it had approved the final round of grants. In total, 539 applicants received funding through this program, with awards ranging from \$1,500 to \$1 million. The median award was about \$263,000. New York received the most funding through this program, with a total of over \$32.5 million among 74 recipients.¹¹

Provider Revenue Streams

Hospitals and physicians experienced significant disruptions to patient volumes due to the suspension of most elective surgical procedures as mandated during the early months of the emergency declaration. Such mandates are now being reinstated in certain areas of the country experiencing more recent surges in COVID-19 cases. Furthermore, many patients chose to delay doctor visits as they followed shelter-in-place orders, and some continue to avoid visiting medical facilities where they face potential exposure to COVID-19. This abrupt decline in volume and change in service mix put a strain on hospitals, since much of their profit is derived from surgical procedures and outpatient activity. Physician groups experienced similar revenue declines, as patients avoided office visits and specialists were unable to perform surgeries that usually comprise a significant part of their practices. Some specialties, such as dentists and optometrists, were required to close their practices (with the exception of emergencies) for a period of time based on government mandates, largely in an effort to preserve PPE for front-line health care workers facing exposure to COVID-19 patients on a regular basis.

While the CARES Act and other legislation implemented changes to Medicare payment levels and reimbursement policies to help address some of the volume disruptions and service mix changes, such measures were not enough to fully address the substantial revenue losses providers experienced as a result of the pandemic. To further protect revenue streams, providers should aggressively work with commercial managed care payers to ensure their contracted rates account for these same changes. Payer negotiations should include both short-term and long-term considerations to enable providers to be fairly compensated for the services they provide.

Hospitals and Health Systems

Hospitals and health systems should reach out to their largest commercial payers and work towards rebalancing their contracted rates to enhance payments for medicine services over surgical services.

This can be accomplished in several ways, including the following:

- » For DRG-based contracts, providers should ensure that updates CMS makes to DRG weightings to effectuate the 20% increase for COVID-19 related DRGs are also adopted in the DRG weight tables used by commercial payers. Some payer contracts automatically follow CMS DRG weights, but many contracts use custom weight tables or DRG weights fixed to a specific year. It is important for providers to ensure their contracts reflect any weight enhancements implemented by CMS.
- » Hospitals could also examine year-over-year volume changes to determine how COVID-19 has impacted their service mix, then negotiate with payers for a one-time payment to make up for the difference in revenue that is attributable to the service mix change. Contracted rates and associated insurance premiums are established based on historical utilization patterns. The COVID-19 disruption represents a material volume shift from historical patterns that could not have been predicted. Accordingly, providers should work with payers to account for such a dramatic shift in volume and service mix.
- » Hospitals should benchmark their charge masters and negotiated contracted rates and examine how their charge levels and rates sit relative to the markets they serve. Charges should be adjusted to maximize contract performance while keeping overall rates within market levels. Contracts with reimbursement rates below market medians should be examined and renegotiated to ensure they are optimized.

Physician Groups

Multi-specialty physician groups containing a mix of primary care physicians and specialists should examine their commercial contracts and pursue a similar rebalancing by shifting dollars from surgical procedures to evaluation and management (E&M) services. Enhanced E&M rates could be implemented on a temporary basis (i.e., through the duration of the emergency designation), and the enhancements removed after the COVID-19 crisis passes.

Additionally, as CMS has expanded the use of telemedicine services by approving reimbursement for previously unreimbursed services, commercial payers should follow suit. Providers should work with commercial payers to ensure reimbursement rates for telemedicine services are equal to the rate for an equivalent service performed in a non-telehealth setting, potentially adjusted to reflect any increase or decrease in the costs associated with such services (i.e., increased technology costs and/or decreased supply costs).

Finally, there is much discussion within the health care industry that the fallout from the COVID-19 crisis has highlighted the need for a change in the reimbursement philosophy, particularly as it relates to primary care. Both the disruptions to the volume of patient visits and

the disparity in overall health of various segments of the population are likely to reinvigorate momentum for a shift away from fee-for-service reimbursement to value-based approaches. Value-based payment systems could lead to a more consistent revenue stream for providers. At the same time, those providers would be incentivized to increase their attention to population health, including preventive care and management of chronic conditions in order to lower the overall cost of care for the patients they serve.

- » Extending compensation guarantees or implementing base salaries for key physicians who are negatively impacted by current volume disruptions but will be required for the health system to maintain adequate care for the community after the crisis subsides; and
- » Temporarily reducing compensation for non-critical physicians whose volumes and associated collections have been negatively impacted by the disruptions.

Physician Compensation

Changes in visit and procedure volumes have also impacted compensation for the many physicians who are compensated based on work RVU production models or collections-based models. These physicians are directly impacted as volume and service mix shifts occur due to directives to halt elective procedures, patients choosing to delay routine visits, shortages of PPE required to safely provide care, and other shifts in resources as providers deal with severe financial constraints brought on by the COVID-19 crisis.

This circumstance is forcing practice and health system administrators to think creatively to ensure physicians are incentivized to provide services where they are most critically needed, while minimizing losses in other areas of the health system. Some creative ways to address physician compensation issues include:

- » Increasing compensation for physicians working directly with COVID-19 patients (i.e., “hazard pay”);
- » Reassigning qualified physicians as “hospitalists” in areas heavily impacted by COVID-19 cases, and adjusting compensation accordingly;

Any changes to physician compensation levels should be made in a manner to ensure adjusted amounts remain at fair market value for services rendered, or the adjustment qualifies for one of the eighteen blanket Stark waivers issued by CMS on March 1, 2020.¹² While the waivers allow increased flexibility to enable health systems to address the unique impact of the crisis on their organization and the local community, adequate documentation remains important from a regulatory compliance standpoint.

As practices explore shifting more reimbursement to a value-based structure, consideration must also be given to the structure of physician compensation plans. As a greater portion of revenue comes from capitation (i.e., a fixed amount per month per patient on the physician’s panel) or value provisions, physician compensation plans should be realigned to incentivize behavior accordingly. For example, if half of the revenue for a practice comes from capitation but the physician remains on a productivity-based compensation plan, the physician will be incentivized to increase the volume of visits and procedures, and thus compensation, even though such activity may not generate any additional revenue for the practice.

Financial Management During the Crisis

1. Research all available funding opportunities (grants/loans/advances) and determine which one(s) best meet the needs of your organization.
2. Optimize revenue stream:
 - a. Ensure commercial contracts reflect DRG weightings applied by CMS to achieve 20% increase on COVID-19 related DRGs.
 - b. Negotiate with payers to address dramatic shifts in volume and service mix due to COVID-19.
 - c. Adjust chargemaster and renegotiate commercial contracts if needed to align with market levels.
 - d. Ensure commercial contracts include reimbursement for telemedicine services at least commensurate with CMS expansions.
 - e. Prepare for continued shift to value-based payment systems.
3. Adjust physician compensation and/or physician assignments as needed to align with the clinical needs and financial reality of the organization.
4. Plan for the future:
 - a. Budget for multiple scenarios regarding return to pre-pandemic volumes.
 - b. Implement safety protocols for staff and patients.
 - c. Assess technology, staffing, and training needs for increased telemedicine activity.
 - d. Implement plans to achieve compliance with hospital price transparency regulations and determine strategy for utilizing the market data that will be publicly available after January 1, 2021.

After the Crisis

While the focus of providers has understandably been on weathering the storm in the present moment, it is critical for the long-term financial stability of health care organizations for leadership to keep an eye towards the future and what it will look like when we emerge from the COVID-19 crisis.

After honestly evaluating their current financial position, providers should begin planning for their cash needs when the crisis passes and a new normal takes hold. In addition, providers need to assess their ability to serve pent-up demand once directives are lifted (again) and surgical volumes begin to return to pre-pandemic levels. Providers should plan for varying volume and staffing scenarios since it is unclear whether volumes will return immediately, whether there will be a slow build as patients remain tentative about undergoing medical procedures (either from continued fear of exposure to COVID-19 or due to financial constraints resulting from the economic downturn), or whether volumes will ebb and flow along with surges and declines in COVID-19 cases in specific geographic areas over the coming months.

Until there is an effective COVID-19 vaccine, protocols and safety measures must be implemented to ensure the continued safety of patients and staff. All planning should take these enhanced safety measures into account, including developing appropriate processes and procedures as well as procuring required supplies and equipment. Effectively communicating safety measures to patients will also be a critical step in ensuring that they feel it is safe to visit the facility when care is needed.

The increase in telemedicine activity accelerated an already existing trend, and this change will impact facility and staffing needs for providers. Telemedicine and technology should definitely factor into a provider's plan for future operations. As a result of certain restrictions associated with telehealth activities being relaxed during the emergency, many practices scrambled to implement these services. A recent survey of American Academy of Family Physicians (AAFP) members indicated that 81% provided telemedicine visits for the first time during the crisis, and 69% expressed a desire to continue such services going forward.¹³ Already, federal legislation has been introduced to make permanent some of the relaxed rules that were enacted during the emergency and expand the use of telehealth for Medicare patients. The bipartisan bill proposed removing geographic restrictions on where a patient must be located to use telehealth and allows telehealth services to be provided to patients in their homes. Further, it extends access to federally qualified health centers and rural health clinics.¹⁴ Time will tell what provisions are included in legislation that ultimately gets passed by Congress and enacted into law, but there are clear signals that the industry is unlikely to revert to the restrictions that were in place prior to the COVID-19 crisis. Telehealth has been proven as a way to offer patients convenient and effective care, and both patients and providers will demand continuation of this avenue of care in some form going forward.

In addition, while hospitals and health systems have been appropriately focused on addressing the COVID-19 crisis, a district court judge issued a ruling in June that upheld CMS's price transparency rule, which is scheduled to become effective on January 1, 2021.¹⁵ This rule will require hospitals to make all negotiated rates for hospital services available to the public, and it could have broad implica-

tions on health care consumerism and how rates are set by hospitals. Health systems must take immediate steps to ensure compliance with the requirements before the deadline, but leadership should also start considering how to use all the newly public data to optimize their strategic position once the deadline passes.

Finally, the crisis has forced everyone in the health care industry to think differently about how care is delivered and what types of contingencies need to be planned for. The government has made available billions of dollars in an attempt to bridge the funding gap during the crisis. The U.S. (and much of the world) has experienced a forced shutdown of its economy at a scale that is unprecedented in our lifetime, while at the same time our medical professionals have been tasked with determining effective ways to treat a previously unknown illness. In the chaos of the present, the seeds of new opportunities are being planted that will drive new alliances, new ventures, and new ways of working. It is important that entities do all they can to remain stable and strong through the current uncertainty so they will be well positioned to engage in new opportunities when they arise.

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Guide to Financial Arrangements of Health Care Management Services Organizations

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Introduction

Management Services Organizations (MSOs) in the health care services industry play critical roles in the delivery of patient care in the United States. Although their roles vary greatly across the industry landscape, the most common intentions are to align provider services and business services to create value by improving quality, access, efficiencies, and cost. Moreover, MSOs have gained significant popularity in recent years and are expected to continue on a growth trend. This guide will provide a deeper understanding of financial arrangements of MSOs as a pillar for success for all parties involved.

First, this guide introduces the provider MSO structure from an organizational and financial perspective, followed by five steps to sound financial management of MSO arrangements. Next, the discussion examines on a deeper level various arrangements between certain providers (e.g. hospitals, physicians, and care innovators) and unique MSOs. Recognizing the start-up nature of many MSOs in today's market, this guide will then shift to effective financial management of newly established arrangements. Given the high transaction volume and robust regulatory environment in which MSO arrangements operate, the final topics will be centered on fair market value (FMV) payments and compliance maintenance. Through the framework of this guide, providers, managers, and key stakeholders will strengthen their knowledge of MSO financial arrangements to be better prepared for successful launch and growth endeavors.

Overview of MSOs

The general structure of a health care MSO arrangement involves two main parties: a provider organization and a management services

organization (also referred to as a manager). The term “provider” in this context can be broadly applied to professionals and/or facilities providing direct health care services to patients. Patient service revenues are generated and billed through the providers using their contracted rates. Providers include, but are not limited to, hospitals, physician groups, and independent freestanding specialty clinics. As such, the landscape is comprised of a wide variety of provider organizations party to MSOs, which requires the managers to tailor specific management services and expertise to each unique arrangement. For example, a manager for an interventional radiology provider may be more focused on equipment and facility operations for a small group of direct physician users, while a manager for a physical therapy provider may be more focused on strategic planning of clinic locations and therapist staffing models for a broad network of referring physicians.

The business case for MSOs can be thought of in terms of goodwill¹ value. Without the MSO, the provider performs all operational services and retains all excess earnings that drive goodwill value. Under a MSO arrangement, some of the services (and profits associated with providing those services) are shifted to the manager. Hence, some of the goodwill value is also shifted to the manager under the MSO. It is expected that the combination of the provider and manager strengths through the MSO arrangement will enhance the value and quality of the entire service and business activity. Overall, goodwill value increases to the benefit of both parties. Table 1 on page 32 is a hypothetical example of this concept assuming the same service line with and without a MSO. Note, it is assumed without a MSO, business management of the service line is internal within the provider organization. Therefore, the provider is more heavily involved in nonprofessional business management.

Table 1. Goodwill Value for the Provider and MSO

	<u>Without MSO</u>			<u>With MSO</u>	
<u>Enterprise Attributes</u>	<u>Management (Internal)</u>	<u>Professional Provider</u>		<u>Manager (MSO)</u>	<u>Professional Provider</u>
Contact with Patients		X		X	
Contact with Suppliers	X				
Barriers to Entry	X			X	
Innovation	X			X	
Quality	X			X	
Specialized Licenses/Expertise		X		X	
Source of New Patients		X			X
Referrals Made To		X			X
Advertising & Professional Relations		X		X	
Number of Locations	X			X	
Owner Presence		X		X	
Reputation	X			X	
Billing Method	X			X	
Trained Workforce	X			X	
Competitive Advantage		X		X	
Compliance	X			X	
Management Depth	X			X	
Professional Provider Goodwill Allocation	60%			40%	
Management/Manager Goodwill Allocation	40%			60%	
Enterprise Goodwill Value	\$1,000,000		<i>Increase</i>	\$2,000,000	
Professional Provider Goodwill Allocation	\$600,000		2.0x	\$800,000	
Management/Manager Goodwill Allocation	\$400,000			\$1,200,000	

The list of enterprise attributes without a MSO are weighted more toward the provider, but shifts to the manager with a MSO. Assuming the parties perform, the shift in attributes increases the overall goodwill and allocated goodwill value for both.

The dynamics of this model depend greatly on the type of arrangement. For example, physicians in a practice with a MSO likely experience an overall decrease in provider goodwill value. However, if they also hold ownership in the MSO, they should participate from an increase in manager goodwill value. In order to better understand the value creation, the discussion will shift to more specifics as relates to the structure and financial mechanisms of MSO arrangements.

While a great deal of variety exists among health care MSO arrangements, one thing they generally have in common is a contract often

referred to as the Management Services Agreement (MSA). MSAs define the roles of the parties, terms of the contract, and the specific management services being provided. From a financial management perspective, the most important aspects of MSAs are the compensation terms and the scope of management services because each of these will translate directly to income statement line items impacting both parties. A simple MSO structure is illustrated in Figure 1.

In addition to the basic structure illustrated in Figure 1 below, it is common to see arrangements with additional compensation outside of the MSA. For example, the MSO can often be a lessor of real property and equipment to the provider, which would fall under a separate leasing agreement. A simple illustration building on the previous structure is shown in Figure 2 on page 33.

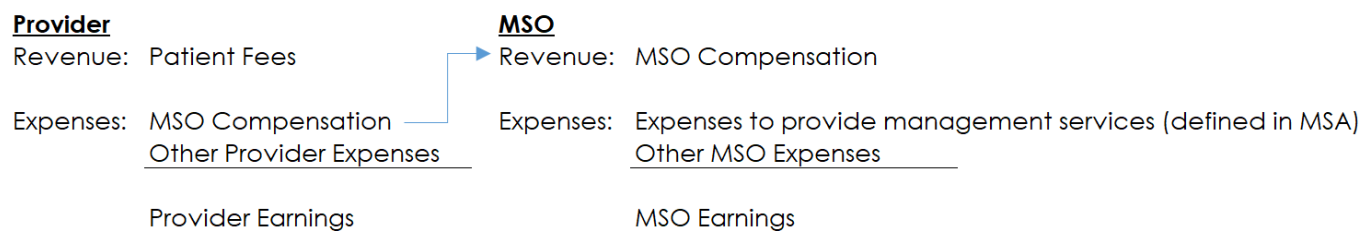
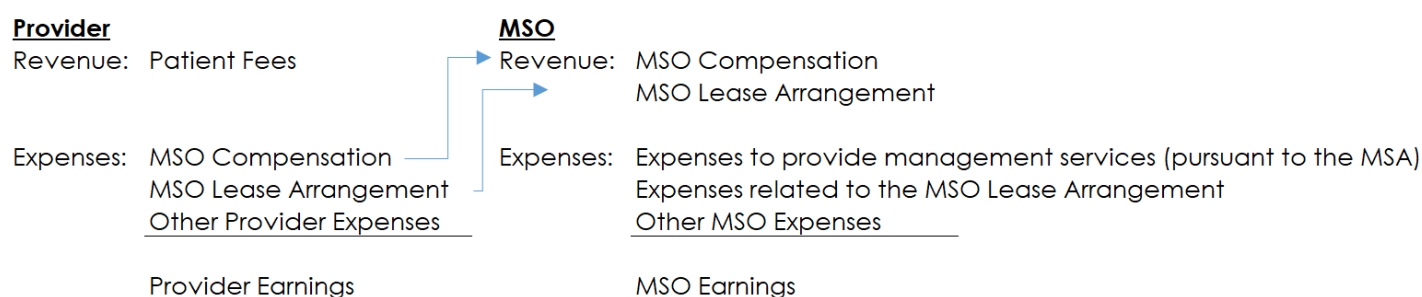
Figure 1. Basic MSO Structure

Figure 2. Compensation Outside the Basic MSO Structure

Five Steps for MSO Financial Management

Now equipped with a basic understanding of the provider and manager roles and the financial framework, this section will provide five steps to sound financial management of MSO arrangements.

1. As previously mentioned, focusing on patient fee revenue at the provider level is the first step of MSO financial management. Both parties need to understand the variables of patient revenue such as revenue concentration (dependent on few or many services, providers, or patients), payer mix and contracts, collectability, and accounts receivable turnover. A billing and coding audit may also be performed for further revenue assurance. Recognizing that this revenue belongs to the provider, the manager plays an important role in the patient revenue cycle based on effectiveness of the management services.
2. Because it is such a material part of the arrangement, parties often jump to focusing on the MSO compensation amount. However, a better approach in managing the financial structure of the arrangement is to next focus on the expenses incurred by the manager in providing the management services pursuant to the MSA because the MSO compensation is often derived directly from these expenses, as discussed later. Expanding on the expenses attributable to providing management services, a typical menu of services is as follows:
 - » Financial, cost, and operational reporting and budgeting
 - » Billing and collecting on behalf of the provider
 - » Accounting, business office, revenue cycle, and decision support functions
 - » Scheduling, pre-authorizations, and patient follow-up
 - » Internal controls design and risk assessment
 - » Establishing non-clinical policies and procedures
 - » Establishing, measuring, and achieving quality goals
 - » Facility space and equipment planning, procurement and maintenance
 - » Vendor contracting including medical supplies and device procurement
 - » Information technology hardware, software, and network management, including electronic health record systems

- » Third-party contracting for professional, consulting, or other outside services
- » Payer contracting
- » Human resources functions including payroll, benefits, hiring, terminating, and training
- » Advertising, public and provider relations
- » Regulatory compliance with Centers for Medicare & Medicaid Services (CMS), The Joint Commission, or other state and federal authorities
- » Other managerial decision making and corporate governance

Management services could include some, all, or more from this menu, which is one main reason there is no one-size-fits-all MSO or MSA. Moreover, the scale of these manager functions in terms of time, manpower, capital requirements, and expertise also vary greatly among arrangements. Once the scope and scale of services are well understood from a financial perspective, providers and managers are in much better position to execute strategies. Scalability is a critical, proven key to success for the stakeholders endeavoring to improve the value equation—this will be discussed in subsequent sections.

3. At this point, it is likely intuitive that managers will require a certain level of compensation to achieve their financial goals, much like any other business. However, an important distinction in the health care MSO industry is that in order to have a legally compliant arrangement, compensation must be at fair market value and be commercially reasonable in order to meet exceptions and safe harbors pursuant to Stark Law, Anti-Kickback statutes, and certain state laws. Some exceptions exist, but for the purposes of this guide, it is assumed compensation must be compliant. As such, FMV and commercial reasonableness will be discussed in further detail later.

Several variations of compensation models exist in the market with some of the most common being fixed or flat fee, percentage of provider revenue, manager costs plus a defined mark-up, and other bonus and risk-based models. Many MSAs also have a mix of these models. Whichever models are used, they must make sense from the financial perspective of both parties. When negotiating MSAs, collaborative and transparent analyses are always encouraged so that both parties understand each other's goals and strategies, and so that the arrangement as a whole is reasonable.

4. Alongside the manager, the provider must also identify its other expenses apart from MSO compensation. For example, hospitals will likely have certain clinical and overhead expenses, and medical practices will have physician professional compensation expenses. Similarly, the manager must consider any incremental costs outside of the MSA such as corporate or capital requirements.
5. Once each of the components of the financial statements are established, it is critical to perform a reasonableness check of the arrangement as a whole. In other words, ignoring payments between the parties, create an enterprise income statement using patient service revenue and total expenses of the provider and manager. One should consider whether the implied total earnings from an enterprise perspective reasonably allocated to each parties' implied profit splits through the arrangement. The parties' margins and splits may also be analyzed in total dollars, with financial ratios and rates of return. The key qualitative factors to consider during this analysis are: (1) whether the financial arrangement makes sense for both parties relative to their risks; and (2) whether the arrangement provides a reasonable framework to provide quality patient care and/or meet certain health care needs. This step in the financial analysis will ultimately tell the story of these qualitative factors.

In summary, the general steps toward sound financial management of MSAs are: (1) establishing provider-based patient revenue; (2) establishing manager expenses pursuant to the scope and scale of the MSA; (3) establishing a reasonable MSO compensation model relative to both parties; (4) considering other expenses outside of the MSA; and (5) holistically analyzing the arrangement. Whether focusing on quality improvement, cost efficiencies, or return on invested capital, the provider and manager should now be aligned to achieve individual and collective goals through an MSA arrangement. From this framework, the discussion will move to more specific types of arrangements common in the industry.

Hospital–MSO Arrangements

Hospital–MSO arrangements continue to be a major part of the health care delivery system spanning a wide variety of inpatient and outpatient services. Hospitals generally leverage clinical expertise, brand name, reputation, payer contracts, and market presence. MSOs generally leverage expertise in administration and operations, physical site and equipment development, access to capital, and professional relationships. Moreover, scalability is one of the most important factors of these MSO arrangements. As platform managers are able to efficiently serve multiple service lines or multiple hospitals, the economics improve for both parties by way of cost management and fair management fees. These arrangements also provide an important competitive advantage as a faster vehicle for speed to market.

As hospitals continue to face capital constraints, they look for ways to meet the health care needs of the community to keep up with growth, demographics, and technology. For example, if high demand exists for a growing service line such as outpatient spine procedures, a hospital will partner with a MSO that has the right expertise and access to capital to design and build out the physical and managerial functions. For the more capital-intensive arrangements, particularly in off-campus

outpatient services, the manager will often take on the primary risk of purchasing or leasing the physical assets, including real property and equipment. Physical assets add another layer to the arrangement outside of the MSA.

Generally for real estate leases—whether the manager is primary landlord or sub-landlord, the rent and facility expenses are a direct pass through to the hospital. Two important areas to examine are: (1) any potential mark-ups to the lease for FMV compliance; and (2) from a risk perspective, each of the parties' terms, such as effective dates and termination rights. An example of increased risk for the manager that is related to real estate may be one in which the manager has a long-term lease or owns the space, but the sublease to the hospital has a one year term and either party can terminate without cause with 30 day notice. Assuming no mark-up on the FMV sub-lease, it would be reasonable for the manager to analyze the aggregate compensation of the arrangement to account for overall risk and required return.

The expenses for high cost equipment and leasehold improvements for services such as diagnostic imaging and radiation therapy are often borne by the manager and leased to the hospital. The same financial considerations apply from the real estate discussion above with the added challenge of monitoring capital expenditure requirements along the depreciation horizon. In light of the overall arrangement, considerations should be made for whether the return on invested capital and internal rate of return make sense and whether there is sufficient cash flow for future capital expenditures. When financials do not align as expected, adjusting MSA compensation (within FMV) may be the best way to re-align required outcomes. An example of an adjustment could be a bonus based on collections thresholds.

Other forms of hospital–MSO arrangements do not involve capital assets and consist only of the MSA. These are common for on-campus hospital services such as surgery departments. In this context, more complex MSAs include a compensation component based on quality and performance measures. Generally speaking, this component starts at full compensation for meeting 100% of the measures, and then decreases on a scale relative to the measures. In other words, there is more downside than upside for the manager. This type of arrangement poses an analytical challenge whereby, at a single point in time, the hospital could benefit financially by way of lower quality which lowers MSA compensation expense. However, it stands to reason that due to lower quality, hospital reimbursement and utilization would also be negatively impacted. Recognizing a lag between the impacts of low quality to the manager and the hospital, the best way to address this challenge is forecasting to a future period until both manager and hospital have normalized average financial statements for comparison.

One final highlight for these types of arrangements is the importance of managing complex systems including electronic medical records (EMR), IT, coding, and billing. As previously discussed, solidifying the patient revenue cycle is step one for sound financial management in any MSO arrangement. Therefore, when the manager is responsible for mastering these systems and functions, the success of the arrangement is heavily dependent on its investment, training, and collaboration with the hospital. Likewise, the hospital is responsible for providing the tools and resources for their systems to the manager.

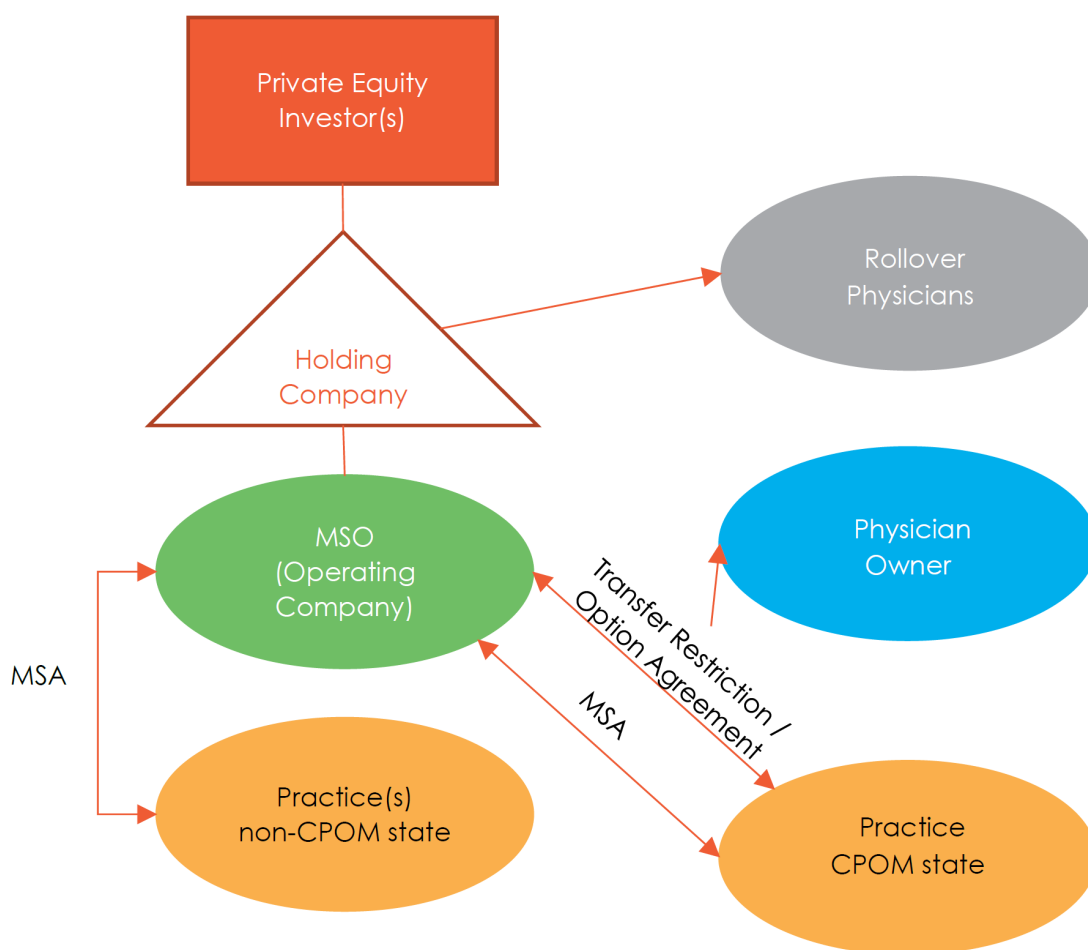
Private Equity Perspective: Physician Practice–MSO Arrangements

Over the last decade, marked initially by the passage of the Affordable Care Act, physician practice merger and acquisition transactions have been a major force in the health care industry. In particular, as a horizontal integration strategy, private equity funds have been major players in acquisitions of practices through MSO models in an otherwise fragmented market. Earlier in the decade, private equity investments in retail specialties such as dermatology and ophthalmology proved successful, and has since expanded into other hospital-based and office-based areas such as anesthesia, surgical specialties, and even primary care. Again, scalability is a leading value driver (1) as MSOs concentrate administrative costs so that physicians can focus on high quality patient care; (2) with size, MSOs can leverage a better negotiating position with payers; and (3) in new capital, which can fuel growth in patient services.

Arrangements involving private equity, physician practices, and MSOs have very unique structures in terms of ownership and how the funds flow. A basic organization chart and flow are illustrated in Figure 3 below. Note, because certain states with Corporate Practice of Medicine (CPOM) laws restrict non-hospital corporations from employing physicians, clinical services and assets must be completely separate from management services and assets. This nuance creates additional due diligence requirements to understand the potential value transferred to the MSO to attract investors. Additionally, compensation to the MSO by the physician-owned professional entity must be compliant with fair market value.

Beyond the structure presented, ancillary services are often included as high-value drivers in the MSO arrangement. When referral relationships exist with physician-owners in the arrangements, compensation to the MSO must also be compliant with fair market value.

Figure 3. Arrangements Involving Private Equity Investors²



The basic mechanisms of these types of arrangements often begins with a compelling offer and business valuation from the private equity firm for the practice acquisition. In these arrangements, terms generally drive valuation post-transaction, and the physicians continue to generate enterprise revenue and earn professional compensation through provider entities. Physicians, however, take a reduction in professional compensation in return for upfront proceeds, paid via cash or rollover stock consideration. If the physicians rollover stock, they will participate in equity returns through the MSO alongside the private equity investors and other physician rollover owners.

From a financial perspective, each party will ultimately measure success to some degree through return on equity throughout the private equity investment cycles, and while the physicians ultimately generate top line revenue, the heart of these arrangements is the MSO and its ability to execute on compliant value propositions.

MSOs for Health Care Innovators

At the time of this guide, the global COVID-19 pandemic has significantly impacted the health care services industry. Due to quarantining and social distancing, CMS quickly realized that health care delivery had to shift to remote options. Telemedicine boomed as CMS and commercial payers removed many of the historical compliance and reimbursement roadblocks. Care innovators—those who have adapted and created new ways to provide patient care—are at the forefront of adopting MSO models to grow.

Information technology is the major force behind many of the innovating companies, which has brought into the health care services industry new players such as Silicon Valley investors and software developers. Because MSO models have proven success through size and scale, these new players are able to very quickly bring to market innovative provider-based solutions.

The managers' value in these arrangements is heavily weighted on IT expertise, which requires a different way of thinking about the cost-risk-return relationship. In other words, the financial arrangement may reflect the MSOs providing something quite different than a typical basket of management services or commonly used equipment and technology. Many of these innovators are start-ups in nature, which leads to a discussion of how to financially manage a brand new MSO in the market.

Financial Management for MSO Start-Ups

In addition to the innovators, many traditional start-up MSOs enter the health care services industry every year. This section will provide insight and considerations for newly established MSOs.

Creating a pro forma is an important first step in deciding whether or not to utilize an MSO. The MSO should determine what functions it will provide for the operating entity(s). However, this can take many forms; activities performed by the start-up MSO may be simpler in nature and include accounting, human resources, marketing, billing and collections, or other administrative-type functions.

It can be helpful when determining actual costs for an organization to assign expense line items for the different functions that they are providing to an operating entity. This will likely include both direct and indirect expenses. Payroll costs for individuals that are providing the accounting function can usually be identified easily as a direct cost. This can become a little more challenging when the MSO is providing services for several operating entities. However, in this case, the manager may find it useful to allocate costs by number of hours spent performing the accounting function for each specific operating entity. Examples of indirect costs may be rent expense related to lease space for manager employees, software costs, utilities, and salaries and wages for management personnel. Indirect cost allocations are often based upon a relevant measure assigned to a function. It is important to utilize a measure that is easily trackable and designated to a specific activity. This measure should be consistent from period to period.

A manager may take advantage of a broad approach to determine a reasonable mark up to actual costs for management services and risks incurred by the MSO. "Reasonable" can be a rather vague term; therefore, comparing costs and risks to industry benchmarks can provide a helpful gauge. In addition, the manager should review the financial operations of the operating entity to determine if the cost being charged makes sense in proportion to the operating entity's revenue and expenses. If this is out of line, the manager should adjust accordingly. Mark-ups determined through a broad approach should not be considered in any legal contracts, but can serve for modeling and budgeting purposes.

Understanding the revenue cycle of the operating entity(s) will be important to the MSO. If the MSO is not providing the revenue cycle services, it is still important that they are acutely aware of how the revenue cycle of an operating entity is performing. Patient revenue cycles have extremely complex rules and regulations that, if not actively managed and monitored, can have detrimental effects on both the manager and operating entity.

It is also prudent of the MSO to determine appropriate key performance indicators (KPI) for the operating entity. These KPIs should be measured against industry benchmarks for the operating entity's location and practice specialty. Important KPIs to measure may be the labor to revenue, drugs to revenue, supplies to revenue, labor turnover, overtime usage, accounts receivable aging, and patient volume. Having both financial and non-financial KPIs will provide a more holistic view of the health of an organization.

In whatever manner a new MSO chooses to structure the services they provide, these should be documented in a legal contract, such as the MSA. This reduces the risk of potential blurred relationship lines between the MSO and the operating entity. This can also be beneficial in defending against potential Stark law violations or kickback accusations. To that end, the next section expands upon regulatory compliance matters.

FMV and Commercial Reasonableness

As previously mentioned, in order to be legally compliant, health care MSO arrangements are more often than not required to meet certain exceptions under the Stark Law and safe harbors under the Anti-Kickback Statute (AKS). Arrangements can be compliant in accordance with the professional services arrangement exception criteria for Stark³ and the similar personal services and management contracts safe harbor criteria for AKS⁴.

From a financial perspective, the most critical criteria for compliance lies with fair market value compensation and commercial reasonableness. Stark states that compensation must be set in advance, does not exceed FMV, and does not take into account volume or value of referrals. Stark also expands on FMV of compensation stating it must be commercially reasonable and furthers the legitimate business purposes of the parties. Similarly, AKS states that aggregate compensation is set in advance, does not exceed FMV, and does not take into account the volume or value of referrals.

At the time of this article, final changes to Stark and AKS related to FMV and commercial reasonableness are under consideration. One notable change that was proposed is that parties would not necessarily have to demonstrate profitability to be compliant. This is an interesting area to monitor because a hurdle could be removed for arrangements intending to meet certain health care needs, albeit without all parties recognizing profit.

For FMV compliance, a third-party valuation of the compensation arrangement is required. This includes all aspects of management fees pursuant to the MSA and lease payments for all physical assets. To provide insight into the valuation process of MSA compensation, professional standards set forth three approaches to value: the Cost, Market, and Income Approaches. In general, the Cost Approach takes into account the direct and indirect costs of the MSO for providing its services and applies a supportable mark-up for a value indication. The Market Approach applies metrics from comparable arrangements in the market when applicable. An Income Approach is traditionally a discounted cash flow analysis (however, that rarely applies to MSA compensation). Therefore, better alternative methods include sensitivity analyses tailored to the specific economics of both parties. Prudent valuations take into account the financial arrangements holistically and specific to the parties.

For established MSOs, the analysis is often based on historical financial information. Alternatively, for start-ups, the analysis is based on pro forma financials. So not only is the pro forma integral for financial planning a new arrangement, it serves as a critical basis for compliance.

It is very important to periodically review existing or new fee arrangements in light of FMV, at least on an annual basis. With time, actual performance can be materially different than previous assumptions or historical performance. It is not uncommon for MSO fee arrangements to move outside fair market value due to a host of factors. For this reason, many MSAs explicitly call for annual FMV reviews as part of the parties' compliance plan.

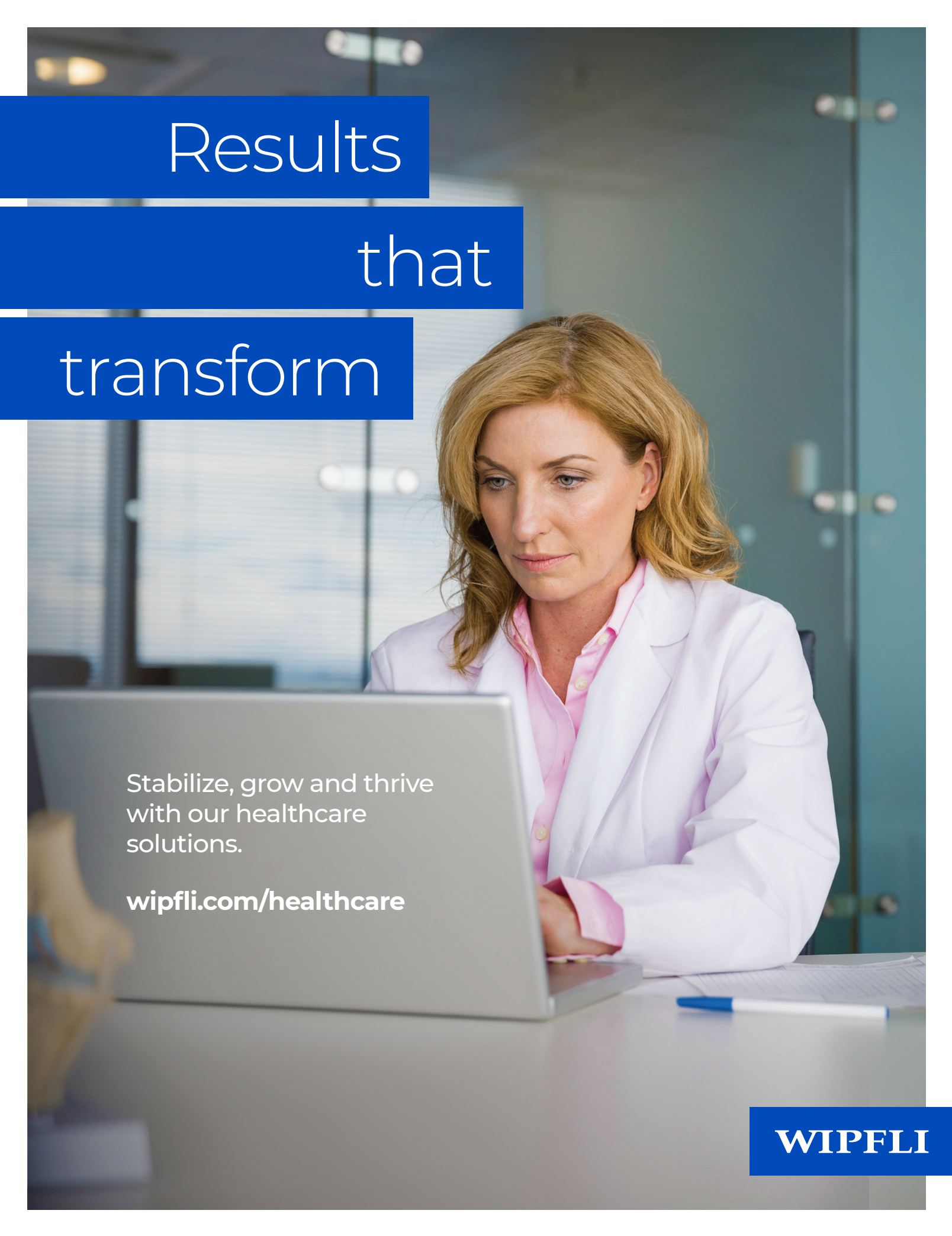
The FMV review should include a qualitative assessment of the arrangement such as any material changes in operations. A quantitative review focuses more on actual and prospective financial results relative to the contractual compensation terms in order to determine if FMV still applies or if adjustments are required. In summary, establishing and monitoring FMV compliance will keep all parties on a path to success.

Conclusion

MSOs continue to propel health care services in the U.S. among a wide variety of providers and stakeholders. This guide set out to provide an overview of MSO arrangements, steps to take for solid financial management, provided a deeper dive into specific types of arrangements, and brought attention to compliance matters. In the end, hopefully these topics bring light to an exciting, growing area in the health care industry.

Endnotes

- 1 Goodwill—that intangible asset arising as a result of name, reputation, customer loyalty, location, products, and similar factors not separately identified. *Statement on Standards for Valuation Services No. 1: Appendix B – International Glossary of Business Valuation Terms*.
- 2 Figure 3. adapted from a presentation at the Healthcare MSO Conference, a DealFlow Event in New York N.Y.: Michele A. Masucci & Michael I. Schnipper, *Corporate and Regulatory Issues in Structuring Healthcare MSO Transactions*, NIXON PEABODY, LLP (Sept. 27, 2019).
- 3 42 C.F.R. § 411.357(d).
- 4 42 C.F.R. § 1001.952(d).

A woman with blonde hair, wearing a white lab coat over a pink shirt, is sitting at a desk in a modern office. She is looking at a laptop screen. The background shows office windows and glass partitions.

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Capital Financing During Uncertainty: How Due Diligence Helps Streamline the Process and Improve the Outcome

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When a healthcare client wants to discuss their growing capital needs, it may be due to changing priorities or concern about how they will access capital. This article will dive into why strategic capital planning is the right path to take and address other considerations, such as factors that are driving the need for capital, barriers to accessing capital, what strategic capital planning involves, today's financing options, and other key questions that should be considered.

Why Do Healthcare Organizations Need Access to Capital Right Now?

For many years, one of the biggest trends that healthcare facilities have been a part of is decreasing their number of inpatient beds and investing more in outpatient care. Now that the COVID-19 pandemic has created the need to isolate or distance patients, many hospitals are planning for capacity issues and are rethinking their facility investments and master facility plan. They are asking some critical questions, such as what does our campus look like, and where do we need more space? Do we need a free-standing ICU? How do we adjust the flow of waiting rooms? Do we need to upgrade the air circulation systems? How can we accommodate drive-by testing, imaging, and prescription pickup? How do all of these necessary changes impact our commitment to team-based care? These questions merely scratch the surface of issues that must be addressed when considering facility investments into the future.

The COVID-19 pandemic immensely accelerated the use of telehealth and telemedicine services.¹ Many healthcare organizations² did the best they could to quickly ramp up their telemedicine services out of urgency and sheer necessity, but not necessarily in a thoughtfully planned manner given the speed at which COVID-19 was spreading and continues to spread. Now that some time has passed since the first coronavirus case in the U.S. was confirmed, healthcare organizations are even more motivated to better understand the investments they need to make in the people, processes, and infrastructure necessary to offer telemedicine services in a more efficient and effective manner.

Pre-COVID-19, telemedicine struggled to launch or gain traction mainly due to commercial and governmental payers' reluctance to reimburse providers; however, the recognition of its safety in terms of being able to provide care while socially distanced and its ability to increase access to patients during a public health crisis has temporar-

ily changed those reimbursement rules. Increasing use of telehealth and telemedicine is also helping to solve longstanding issues related to physician shortages and lack of healthcare access in rural areas. Although there has been some discussion of "rolling back" reimbursement for telemedicine services, such discussions have not diminished the desire of healthcare organizations to invest in telehealth and telemedicine.

What Are the Barriers to Accessing Capital?

These are economically uncertain times for consumers of healthcare and healthcare organizations, which have suffered significant losses through shutdowns and varying degrees of compensation for the care of COVID-19 patients. The availability and cost of capital has also become increasingly uncertain, especially for the near term. Investors, wary of the volatility within healthcare, are looking to see which organizations have weathered the storm and whether the volumes will return and stabilize. This volatility is challenging for investors to assess because the answers will likely not be apparent in recent financials, CARES Act monies will have a skewing effect on investors' assessment, and the perspective on recovery is not yet evident.

Investors want to know, has the healthcare organization lost revenue because it could not perform elective surgeries for a period of time? Did it receive funds from the U.S. Department of Health & Human Services or the CARES Act? If the healthcare organization laid off employees, how quickly can it ramp back up if needed? How has the organization operated differently because of the pandemic, and did it operate effectively?

Because of the unknowns involved in healthcare, the historically low interest rates recently experienced do not necessarily translate into lower borrowing costs for healthcare organizations; other factors can determine future viability, such as geographic differences in market impacts and the size and scope of services offered by a healthcare organization. That said, there is still activity in the tax-exempt bond market, as well as a desire for solid credit from commercial banks that are lending to healthcare organizations, but the recent lack in volume has been concerning for lending institutions.

If in the coming months we have more clarity on how the pandemic has impacted revenue, these institutions may loosen up a bit. Thus far, however, it has been a confusing year for both healthcare

organizations and investors looking to evaluate their credit worthiness and wondering if there will be another round of government funding. In addition, many healthcare organizations are concerned about whether they are correctly following often vague government guidance on how funds can be used and how those funds need to be recorded.

The Importance of Strategic Capital Planning

The importance of strategic capital planning and due diligence is highlighted in the midst of healthcare organizations trying to determine their volumes and their full financial picture. Every organization can prepare itself for capital investment by using the process of strategic capital planning, which allows the healthcare organization to calculate how much total money it will need in order to achieve its strategic objectives, taking into account projected financial performance. It estimates credit strength under different scenarios so that a healthcare organization can prioritize its capital investments. When complete, the organization will have made an accurate determination of its capital requirements and when funds will be needed so that it can evaluate its current funds, debt capacity, and financing options. This will enable the organization to start prioritizing its objectives.

Performing Strategic Capital Planning

Strategic capital planning can be conducted internally, assuming the team has both the time and skill set, but even so, the process can be time-consuming and take away from other essential analysis and planning initiatives. Using a third-party resource can not only streamline the process but also bring a high level of experience and objectivity to the table. When a healthcare organization is simultaneously trying to prioritize its needs, stay financially healthy, and weather current and future threats of service disruption, it could be worthwhile to lean on experts who can create a plan that will provide guidance and direction to everyone involved.

Part of the strategic capital planning process involves creating a pro forma of five to ten years that documents assumptions about the future and looks at various “what if” scenarios. Listed below are seven important factors to keep in mind during the development of an organization’s pro forma:

1. **Equipment:** Create a list that estimates the cost and average life of the equipment needed to achieve the targeted projects.
2. **People:** Identify whether the organization will need to add employees and when. Create a list identifying costs around salary, benefits, and other labor concerns.
3. **Processes:** Will any of the projects result in improvements around efficiency (e.g., consolidating services and saving on utility bills with a higher-efficiency HVAC system).
4. **New costs:** On the flip side, the time and effort it takes to implement new projects can often result in a temporary loss of productivity in other areas.
5. **Existing funds:** Evaluating a project’s feasibility and how it will impact the organization’s credit profile requires identifying existing unrestricted funds, grants, debt capacity, and other existing funds.
6. **Financing options:** Calculate conservative assumptions on the cost of capital and financing. Changes in these assumptions and the effect on the credit profile can help evaluate future debt amounts.
7. **Assumptions:** Create a list of external environmental changes that could impact financial performance, both positively and negatively. Examples include changes in reimbursement, decreased volume as a function of the insurer environment and manifest in gross revenues, contract labor increases or inability to recruit, and self-insurance claims for a particular year.

Taken all together, a healthcare organization can make decisions on quantifiable evidence rather than subjective opinions. The “what if” scenarios help clarify the most important levers that will affect outcomes and help build those risks into the planning process.

Looking at Today’s Financing Options

As a healthcare organization explores financing options (and there are many), it is important to weigh the benefits, challenges, and limitations of each option in order to pursue the most prudent choice for the future. Below are several potential financing options.

Banks

We are currently in a historically low rate environment, and as a result, local, regional, and national banks are currently providing very attractive loan rates and terms. However, the challenge in working with banks is making sure they understand the healthcare organization’s specific business model. Banks also often manage risk by requiring a significant equity contribution and by providing loans with interest rate resets. Furthermore, there is significant variation in banks’ understanding of key covenants and ensuring that the financial covenants associated with a loan are relevant.

Both cash for equity and the ability to “weather” interest rate increases can be difficult for a healthcare organization that is subject to reimbursement changes (and cuts) and has a relatively stable revenue stream that cannot increase as fast as the interest rate on the debt.

With interest rates at historically low levels, it may be a time to lock in a longer-term rate.

Tax-exempt Bonds

Tax-exempt bonds are a way in which nonprofit and municipally owned healthcare organizations can access long-term fixed rate debt at a record low rate. Today, investors are attracted to certainty of return, and bonds supply that in a volatile market. Risk, and therefore return, is assessed by the rating on a series of bonds (i.e., a published credit rating from Moody’s, Fitch, or Standard & Poors) that are considered to be investment grade and ranked in order of highest to lowest from AAA through BBB-.

The market for non-rated bonds (i.e., a borrower that does not have a published credit rating) is often referred to as “story credits” and is largely untested given the pause in capital access resulting from the pandemic. These story credits are often smaller free-standing hospitals or senior living organizations that, because of size and lack of peers, are difficult to categorize in terms of a rating, but which are attractive to investors because they provide a better rate of return than many other options (i.e., higher risk). That said, the communications of the business model, market and financial viability of non-rated bonds is paramount to securing the lowest cost for these entities.

Savvy investors will carefully scrutinize the risks of a healthcare organization’s project. They will take into account planning and assumptions of future performance when evaluating financings, which are economic conditions outside the control of healthcare organizations. Almost always, a financial feasibility study prepared by a third party is required as part of the offering statement in these financings. Such a report would detail assumptions and model the potential effects of key success factors, such as uncertainty about the future of Medicare and Medicaid, diminished value of retirement assets, a weak housing market (in the case of senior living), ability to secure providers/healthcare workers, rising construction costs, and/or investment returns on cash reserves.

Government Programs

Government lending programs can be cost-effective alternatives to raising and securing capital. The most active government agencies that offer such lending programs are the Office of Housing and Urban Development (HUD) and the U.S. Department of Agriculture (USDA), depending on the location and type of healthcare entity. Despite the application process being relatively slow, time-consuming, and involving a lot of paperwork, securing such a loan can be well worth it as these options offer low interest rates that are also fixed long term. Factors can include for profit versus nonprofit or municipal and rural versus urban.

HUD 232 Mortgage Insurance

The HUD 232 mortgage insurance program allows both for-profit and nonprofit senior living organizations to access low interest rate loans. Essentially, the HUD 232 offers “credit enhancement” by offering mortgage insurance on the underlying debt, such that the applicant can receive a rate that would only be available to an AA-rated entity (i.e., a published credit rating from Moody’s, Fitch, or Standard & Poors). Applications are taken on a rolling basis.

In years past, HUD has been referred to as the “lender of last resort.” The process to apply and secure monies has generally been regarded as slow; however, the HUD 232 program has streamlined its application process. The new “lean” approach has resulted in reduced processing time and has been further improved by hiring staff with relevant industry expertise.

HUD 242 Mortgage Insurance

The HUD 242 mortgage insurance program is the equivalent program for hospitals and is available to both for-profit and nonprofit hospital organizations. Varying programs address whether the monies will be

used for construction or refinancing, but the process is generally the same. An examined financial forecast is required and has very specific requirements in terms of content. The HUD website provides a list of approved consultants who can perform these studies.

USDA Financing Options

In order for a nonprofit to qualify for a USDA loan, the project must be in a rural area or town with a population up to 20,000. In addition to a grant program—which has been shrinking in terms of availability and offers modest sums on average of \$15,000—there are several types of USDA financing available.

Those most relevant to a nonprofit healthcare organization are the Rural Rental Program and the Community Facilities Loan Program, discussed in more detail below. The latter gives the option for a “Direct Loan” (USDA-administered and paid directly to the borrower) or a “Guaranteed Loan,” which is essentially insurance or a guarantee on a bank loan or bond issue.

USDA loans are awarded by the state USDA office and are competitive among all eligible projects. If a large amount is requested (e.g., over \$5 million), the loan must be approved and be competitive at the federal level (national office). An examined financial forecast prepared by a CPA firm is required as part of the application.

USDA Community Facilities Loan

Historically, the amount of community facilities loan funds available has been limited, but recent allocations to this program have significantly increased over the past decade and are currently approximately \$3 billion annually.

Larger projects can be funded only if they use the Direct Loan in combination with another funding source, a requirement known as P3 or the Public Private Partnership. In addition to the Direct Loan, other financing can come from General Obligation Bonds, a USDA Guaranteed Loan, or other vehicle as long as the Direct Loan and “private” debt are on parity. There is no mandate for the split between the Direct Loan and other loan, but a general rule of thumb is a minimum of 20% should be from private funding.

The Guaranteed Loan program provides a 90% guarantee on the interest and principal on an approved loan made by a bank. Banks are interested in making USDA-guaranteed loans because the guaranteed portion does not count against the bank’s “capital risk ratio,” which is a measure of the bank’s financial strength based on the ratio of assets and capital reserves to loans. In short, a bank can make a guaranteed loan with only the 10% that is unguaranteed counting toward its “risk” or exposure to loss.

Some benefits to the USDA Community Facilities Loan include the following:

- » The loans are fixed for up to 40 years.
- » Once an application is reviewed and approved, the rate is locked in and the recipient of the loan has up to five years to utilize it.
- » The loan documents for the Direct Loan and some parts of the Guaranteed Loan are standard.

Limitations on both USDA loan types include the following:

- » Uncertainty of availability and timing of funds.
- » Potential environmental restrictions (e.g., wetlands, habitat for endangered plant or animal species, toxic waste area, etc.) could affect where an organization can or cannot build/expand, which could increase application processing time.

Today's economic environment, coupled with increased regulation of bank assets, has made government-sponsored borrowing an attractive option. By first understanding the features of each option—as well as their pros, cons, and corresponding fees—a healthcare organization can more carefully consider the impacts of each.

Key Questions to Consider in Today's Financing Environment

Once a healthcare organization understands its options, how does it move forward? There is always more to know when it comes to making effective decisions.

Considering current interest rates and capital accessibility, it is a good time to borrow, but healthcare organizations should incorporate updated expectations of financing rates and options for capital providers into their project planning. The risks, costs, and limitations of the different financing options should be carefully considered within the context of the organization's specific situation. Some important questions to consider are the following:

- » Is the project financially feasible, and does it incorporate new interest rate assumptions into planning?
- » What financing options, other than the capital markets, should be seriously considered?
- » What are the risks associated with each of the financing options?
- » How will a particular financing option affect the healthcare organization's ability to borrow in the future?
- » How much of the financing costs are associated with a particular financing option, and are those costs reasonable?

Lenders are not the only ones proceeding with caution; borrowers are showing increased diligence as well. Even where there is a long-term banking relationship, many organizations are conducting a competitive RFP process and asking detailed questions about terms and risks associated with the debt.

With that in mind, we debunk a couple common beliefs on how best to evaluate debt options and conduct effective diligence.

Common Belief: We should decide on a financier/lender as soon as possible in the capital planning process.

False. It is common for the size and scope of a project to change, and the amount of borrowing can influence the best type of lender for the project.

For example, a hospital that started with the intention to build a replacement facility at an estimated cost of \$40 million realized that its debt capacity would not support that amount of debt. Instead, the hospital decided to build an outpatient surgery center for \$5 million.

In the case of the replacement facility, a HUD 242 loan would have been an appropriate choice, but in the final decision, the local bank provided a cost-effective option. If the hospital had chosen a HUD lender from the onset, they would likely have been tied to that lender. That lender might not have offered the full array of financing products and/or have been as competitive on a smaller financing plan, and it would not be unusual for the hospital to have to pay some type of termination fee.

Common Belief: The Costs of Issuance (COI) should be compared and can differentiate one firm from another.

False. COI includes a number of items that have nothing to do with the financing firm. Examples include title recording, appraisal, and legal counsel. In addition, COIs vary significantly between the types of financing vehicles, with HUD generally having the most costs and bank loans having the least.

That said, commercial bank loans often bury COI in the interest rate, so the best comparison of the costs of financing options is the all-in cost, which is the equivalent calculation of an APR for a mortgage.

Some lenders will also specify the True Interest Cost (TIC) calculation, which includes only the underwriting/origination fees plus the interest rate. The TIC is a better comparison of the costs of using a particular lender than the overall cost of the financing.

The Most Important Determinants

There are a number of considerations a healthcare organization should take into account when evaluating options, especially in today's market where there have been significant changes in covenants and reporting requirements.

In general, lenders are less lenient about allowing organizations to borrow more debt, as evidenced by limits on and/or approval for additional borrowing. Other covenants, such as the debt service coverage ratio (DSCR) (which measures an organization's ability to cover current year interest and principal payment), and days cash on hand (DCOH) (which gauges liquidity by measuring the number of days of cash operating expenses the organization could support if its revenue stream were to be reduced or eliminated), are used by lenders to monitor financial performance and evaluate the likelihood that the debt will be repaid. If an organization falls below this number, then the lender often has the right to call in a consultant or, in extreme cases, declare a default.

Lenders have higher standards for maintaining minimum DSCR and DCOH so that if there is financial trouble, they can intervene earlier. From the perspective of the healthcare organization, this can mean less money to spend on working capital or other special projects since funds must be set aside to meet the debt covenants. More frequent reporting, specifically quarterly and, in some cases, monthly financials and utilization are required to be submitted to the lender, which can be time-consuming. In short, the flexibility of operating the business and the amount of time spent satisfying lender reporting requirements should be an important consideration, in addition to the interest rate.

Performing Strategic Capital Planning Internally versus Externally

Attorneys often work on different aspects of financing, such as reviewing loan documents. Knowing experts who are adept at conducting strategic capital planning can make the attorney's financing work easier.

Hiring an external consultant to facilitate the strategic capital planning process is valuable because there is no question of objectivity. Internal resources can be biased because certain things have always been done a certain way, or they have a strong vision that has not taken everything into account. It helps to have an objective facilitator guide the healthcare organization through generating ideas and holding discussions around key strategies for the future.

Certainly, many organizations can do their own financial forecasting. There are templates and automated tools available for purchase that enable financial projections, and some can interface with a healthcare organization's EMR. However, the organization must make sure that any purchase: (1) is cost effective, (2) will free up time and resources, and (3) is appropriately customizable in a way that allows for modeling the idiosyncrasies of the organization's reimbursement structure.

On occasion, a strategic capital plan is best done by consultants specializing in this area using their own tools and processes, especially in situations where the healthcare organization has a specific question to answer (e.g., start-up of a new service line or location).

Often, a lender will require that a third-party firm perform a financial feasibility study. It may be advisable therefore to have a third-party firm conduct the study first, as opposed to having the healthcare organization internally conduct an initial study, only to then have a third-party firm conduct the study again. Starting off with the third-party results in a more integrated and objective plan also will give the healthcare organization more credibility with lenders.

If the healthcare organization decides to move forward with leveraging a consultant, it should make sure it has a clear understanding of the deliverable. Important questions to ask include:

- » Is a copy of the model included in the engagement pricing?
- » Can the healthcare organization negotiate an annual update fee for the next few years?
- » What level of detail will accompany the report?
- » What level of involvement is needed from the healthcare organization's employees?
- » What type of information has to be prepared by the organization vs. the consultant?

Depending on the nature of the capital project and the credit worthiness of the organization, the intensity of a strategic capital plan will vary, but it will generally encompass market share and financial forecasts.

If, however, the organization chooses the internal study option first, that will still be helpful in terms of providing direction on how much money to spend on which projects, and the results of the internal study can provide a level of comfort to the board when approving funding for the next steps in architectural planning and mechanical/engineering projects. An internal study will also provide the ability to

understand the "what ifs" of a planned project if conditions change, as well as the impact on the affordability of various priorities, which is valuable information during a time when many external drivers are in flux.

This higher level of internal planning also can be used to inform the more detailed feasibility study performed by an independent consultant and required by lenders and/or the capital markets, thereby streamlining what can be an onerous process. In the end, knowing the "what ifs" empowers the organization through objective, reasonable financial expectations.

How Long Does This Take and What Happens Next?

The most commonly asked questions regarding the strategic capital planning process are how long does it take and what happens next?

In terms of timing, the pace is essentially set by the healthcare organization. The process can be as fast or as slow as the organization wants or needs it to be. Strategic capital planning is a very interactive and iterative process because the plan belongs to the organization—the organization is just having someone else, i.e., the third-party expert/consultant, help them develop the plan and model the financial impacts of the plan.

However, the planning process should not be so lengthy that an actual plan never comes to fruition. We often recommend to healthcare organizations a planning timetable of three months, which generally gives them time to get constituents on board, provide feedback, collect data, and perform analysis.

As for next steps, in the best of all worlds, a strategic plan is refreshed annually—or at least the financials are. Healthcare organizations should revisit initiatives to see if they are still relevant, how they were completed, and how they did or did not turn out.

Conclusion

When advising clients, it is important to understand the lay of the land for the capital market and the availability of dollars. Knowing how to advise a client on how to spend their funds appropriately is going to be very valuable as the COVID-19 pandemic continues to impact the healthcare industry. Strategic capital planning is one of the best, most accurate ways that healthcare organizations can determine what capital they need, when they need it, and how to go about getting it.

Endnotes

- 1 The American Academy of Family Physicians uses the word telehealth to refer "broadly to electronic and telecommunications technologies and services used to provide care and services at-a-distance," and telemedicine "as practice of medicine using technology to deliver care at a distance. A physician in one location uses a telecommunications infrastructure to deliver care to a patient at a distant site."
- 2 The author is using the term "healthcare organization" to refer to a wide range of organizations, including physician practices, hospitals, and businesses that serve the healthcare industry, such as telehealth equipment manufacturers.

Educating and Connecting the Health Law Community



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