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2021 Health Care Transactions Resource Guide

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Articles

Let the Buyer Beware: The Need for HIPAA Risk Analysis
in Healthcare M&A Transactions

Steve Cagle, Jon Moore | Clearwater. 3

Defining Private Equity Transactions in Healthcare and
Understanding Deal Options for Medical Groups

Mark Reiboldt | Coker Group 7

Is 75th Percentile Compensation Safe? A Look at the New Definition
of FMV and Its Applicability to Survey Data

Joe Aguilar, Natalie Bell, Rob Holland, Connor Melancon | HMS Valuation Partners 11

Fair Market Value and Commercial Reasonableness—2021 and Beyond

Neal Barker | HSG 21

Ambulatory Real Estate Development: Converging Perspectives and
Objectives Between Health Systems, Physicians, and Developers

Craig Flanagan, Adam Luttrell | Realty Trust Group, LLC 27

The Art of Physician Consolidation

Roy Bejarano, Emma McGregor, Elizabeth Scoda | SCALE Healthcare

Gary Herschman | Epstein Becker & Green. 33

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Let the Buyer Beware: The Need for HIPAA Risk Analysis in Healthcare M&A Transactions

Steve Cagle, MBA, CEO | Clearwater
steve.cagle@clearwatercompliance.com

Jon Moore, JD, MS, Chief Risk Officer and SVP of Consulting Services | Clearwater
jon.moore@clearwatercompliance.com

Healthcare mergers, acquisitions, and joint venture partnerships have surged in recent years, driven by increasing opportunities to innovate, improve quality, and reduce costs. The advancement of new business models and consolidated platforms also has played an important part in the surge.

Over the last decade, strategic acquirers and private equity investors have integrated thousands of Health Insurance Portability and Accountability Act (HIPAA) covered entities and business associates into their portfolios. Through these experiences, they have become much better educated on the regulatory and reputational risks counterparties bring as a result of a privacy or security breach.

In 2020, the number of reported data breaches of more than 500 records grew by more than 25%.¹ Ransomware attacks against healthcare organizations also grew to the highest levels of all time.² Reading about these attacks in the daily headlines, investors often think “that won’t happen to us”—until it does. Any investor who has lived through a nightmare breach scenario within its portfolio is all too familiar with the associated costs, business disruption, and potential regulatory scrutiny.

Past Breaches May Cause Future Liabilities

In addition to future cyberattacks and privacy breaches, buyers need to be concerned about liabilities they may be assuming as a result of the seller’s noncompliance with HIPAA or failure to exercise the required duty of care in cybersecurity practices. It is not uncommon that breaches go undetected and unreported for months or even years, and thus they may not be identified in the due diligence process.

While the seller will typically be responsible for a breach prior to closing, determining and proving when a breach first occurred is often not straightforward, even with the support of expensive forensic experts. If the breach was ongoing and unidentified for some time after the purchase, it becomes even more complicated. Additionally, federal and state regulatory actions and civil lawsuits typically follow for years after a breach, with the buyer left managing an expensive and distracting situation. Failures of the past may weigh heavily on the organization’s future growth trajectory.

Organizations that enter into joint ventures, make minority investments, or establish business partnerships also should take note of potential privacy and security liabilities and business ramifications that may occur from a counterparty’s failure to comply with HIPAA or from its lack of due care in cyber risk management. Companies that partner with organizations that are responsible for safeguarding protected health information (PHI) should assess and limit their exposures in the event the other party fails to implement reasonable and appropriate security and privacy practices.

Review the Counterparty’s Risk Analysis as Part of Due Diligence

For many years, HIPAA compliance and cybersecurity were only worthy of cursory levels of diligence in healthcare transactions. However, today investors (in particular, private equity) and their attorneys are devoting more time and resources to this area. A preventable breach associated with HIPAA failures could be a non-starter for future acquirers and therefore might significantly reduce the value of the company at a future exit. As such, investors now have a stronger appetite to invest in diligence at the same levels they are accustomed to with other traditional categories such as financial, insurance, and intellectual property.

Comprehensive HIPAA compliance and cybersecurity diligence must include a thorough review of the organization’s security risk analysis. It must determine whether the risk analysis is up to date and if it complies with the Office for Civil Rights’ (OCR’s)³ Guidance on Risk Analysis Requirements under the HIPAA Security Rule.⁴ Demonstration of an accurate and thorough risk analysis is critical for several reasons:

1. During an OCR investigation of a breach, one of the first things the assigned investigator will ask to review is the organization’s risk analysis. A failure to conduct an enterprise-wide risk analysis of all of the organization’s information assets according to the OCR guidance is *the most common deficiency* resulting in a civil money penalty or settlement. Failure to perform an adequate risk analysis is cited in 89% of these cases.⁵ Recent OCR enforcement actions support that its focus on compliance with the risk analysis requirement is not going away.⁶

2. As can be inferred from the above, what most healthcare organizations call a risk analysis does not meet OCR's standards. This is true even for larger organizations, which are more complex, and for whom the bar is set even higher.⁷
3. A risk analysis is the only method by which the organization—and the acquirer—can truly know what actual cybersecurity risks exist for that particular organization. A risk analysis is not simply completing a controls checklist. Rather, it evaluates the specific vulnerabilities and threats to the organization's information systems, as well as the controls in place and how well they mitigate risks. By reviewing the risk analysis, the buyer can understand what risks exist and at what level, and determine whether, based on its risk tolerance level, it will need to reduce those risks further. The buyer can work with its diligence consultant to estimate the cost and level of effort involved to reduce these risks, and therefore have better visibility into how much capital investment in the security program is required. As a result, the buyer will have a better sense of the true acquisition cost of the target.

Does the Risk Analysis Meet Regulatory Standards?

A risk analysis must meet OCR's definition and standards to be of any value. Make sure that (a) the review of the risk analysis receives particular attention in the compliance and cybersecurity due diligence process, and (b) the reviewer of the risk analysis is an expert in this area. A generalist cybersecurity firm, accounting firm, or other non-HIPAA Security Rule expert will often not have the expertise required to make this determination.

Healthcare leaders are increasingly seeking the advice of counsel when it comes to risk analysis diligence along with the broader HIPAA diligence process. Many healthcare transaction attorneys will, in turn, ask one of their healthcare and privacy security partners to assist in this area or leverage a third-party healthcare cybersecurity consultant to perform the detailed review and produce a findings and observations report.

Include Satisfaction of 45 C.F.R. § 164.308(a)(1)(ii)(A) in Seller Representations and Warranties

Requiring representations and warranties related to HIPAA compliance along with other regulatory requirements may not be a new concept. What is new, however, is an emerging trend to specifically include representations of compliance with 45 C.F.R. § 164.308(a)(1)(ii)(A) of the HIPAA Security Rule—i.e., performance of a risk analysis. We would go further and suggest that the representations should include specifying that the risk analysis complies with the OCR guidance document previously referenced. Why is this so important? Attesting that the organization complies with HIPAA is

broad, vague, and open to interpretation. It is highly likely that many organizations that paid substantial fines thought they had performed a risk analysis correctly but did not. With risk analysis failure leading the reasons for regulatory enforcement, calling out that it must have been done following OCR guidance may provide more protection for the buyer or third-party partner.

Healthcare leaders are encouraged to consult with their attorney as to whether they should require specific representations and warranties from the seller or partner related to their performance of a security risk analysis that meets OCR standards as stated in its guidance. Attorneys can advise on whether the buyer can seek recourse from the seller if the organization incurs future damages resulting from regulatory actions or lawsuits that occur as a result of a risk analysis failure.

Addressing Lack of, or Inadequate, Risk Analysis

It is quite common to discover through diligence that the target or partner has not performed an adequate security risk analysis that meets OCR's standards. Typical failures of risk analysis include (1) it has not been performed recently, (2) it does not include all of the organization's information assets used to create, receive, maintain, or transmit electronic PHI, or (3) it does address reasonably anticipated threats and vulnerabilities. Additionally, the organization may have failed to respond to the high and critical risks that emerged from the analysis (known as the risk management plan).

As discussed, failure to perform a risk analysis creates a risk of a potentially substantial liability for the company or partnership. In this case, there are several approaches to help reduce risk:

1. **Require that a risk analysis be performed by the seller (or in case of a joint venture, the partner) as a closing condition.** While this may be the optimal approach from a risk perspective, it also could delay the transaction. The ability to accomplish the risk analysis quickly will largely depend on the scope, the availability of the target's resources, and the capability of the assessor to move quickly. Aided by Clearwater's IRM|Analysis® software,⁸ our consultants have completed a risk analysis in less than 30 days. A typical practice would be to create the follow-up risk management plan post-closing.
2. **Require a risk analysis as a post-closing covenant.** This might be a common and adequate approach in partnership agreements, minority investments, or other transactions where the seller or partner maintains control of the organization. This approach may also be more practical when timing and resources are less flexible, and when other areas of HIPAA and cybersecurity diligence provide reasonable levels of comfort that the organization has strong controls in place but has not yet gone through the process of assessing them against risks that are relevant for its organization.

3. **Buyer performs risk analysis post-closing.** In this case, the buyer is acquiring control of the company, and it can opt to perform the risk analysis after closing and should do so as soon as possible. The buyer must be comfortable with accepting the regulatory risk and the fact that until it performs the risk analysis, it will not truly know the potential risks to the confidentiality, integrity, and availability of patient data and the organization's information systems. Performing an OCR-quality risk analysis carries a material cost. The buyer may wish to seek a reduction in the purchase price or request other compensation. Note that there may be additional costs associated with responding to high or critical risks, but those will not be known until after the risk analysis is complete—a further argument for performing the risk analysis before closing.

Reps and Warranties Insurance Trend: OCR-Quality Risk Analysis Required to Underwrite Claims Due to HIPAA Violations

The highly complex regulatory environment in healthcare, along with growing concerns about patient privacy and safety, result in a large number of potential future liabilities that neither party wants to be responsible for. As a result, negotiation over reps and warranties can be one of the most arduous and lengthy parts of the deal-making process. Reps and warranties insurance can solve this issue by protecting buyers from future liabilities. The use of this insurance has become increasingly common in healthcare transactions with private equity firms. We have noticed several trends emerging regarding reps and warranties insurance:

1. **Underwriters are requiring more comprehensive HIPAA and cybersecurity diligence.** Insurers are expecting that the buyer is using a qualified expert to perform an extensive amount of HIPAA diligence as part of its overall diligence efforts.
2. **Risk analysis specifically required to avoid exclusions.** Some insurers are going as far as to specifically require that a HIPAA risk analysis is performed prior to underwriting liabilities related to HIPAA compliance.
3. **Underwriters are relying on the risk analysis as a key input in determining coverage.** In addition to ensuring the risk analysis has not only been completed but also performed correctly, the insurer wants to know what high and critical risks exist and may rely on them to justify further exclusions or limits to the coverage.

Conclusion

While the COVID-19 pandemic has slowed the pace of healthcare mergers and acquisitions temporarily, the trend is expected to resume and likely accelerate as business conditions normalize.⁹ Fueled by the increase in cyberattacks, and damages incurred with their portfolio companies and joint ventures, investors are expected to place increased emphasis on the execution of strong diligence of HIPAA compliance and cybersecurity practices as new deals develop. Risk analysis should take center stage as one of the most important components of compliance with the HIPAA Security Rule. If the target or partner has not performed a risk analysis that meets regulatory standards, it should take action to eliminate the deficiency by performing the risk analysis as soon as possible. Risk analysis reps and warranties can help protect buyers from counterparty failures, as can reps and warranties insurance. Knowledgeable underwriters will often require the insured party attests that it has not only complied with HIPAA, but that it also has performed an OCR-quality risk analysis.

Transaction attorneys play a vital role in developing the right approach and strategy. Clearwater can help conduct HIPAA compliance and cybersecurity diligence, and if necessary, perform a risk analysis on a timeline that helps achieve transaction objectives.

Endnotes

- 1 Office for Civil Rights (OCR) Breach Portal, https://ocrportal.hhs.gov/ocr/breach/breach_report.jsf.
- 2 Liviu Arsene, *Global Ransomware and Cyberattacks on Healthcare Spike during Pandemic*, SECURITY BOULEVARD (May 13, 2020), <https://securityboulevard.com/2020/05/global-ransomware-and-cyberattacks-on-healthcare-spike-during-pandemic/>.
- 3 OCR is the HIPAA enforcement arm of the U.S. Department of Health and Human Services, <https://www.hhs.gov/ocr/index.html>.
- 4 OCR, *Guidance on Risk Analysis Requirements under the HIPAA Security Rule* (July 2010), <https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/administrative/securityrule/rafinalguidancepdf.pdf>.
- 5 Clearwater proprietary database sourced from U.S. Department of Health and Human Services OCR Breach Portal and analysis of publicly announced civil money penalties and settlements.
- 6 Thora A. Johnson, Celia E. Van Lenten, and Ryann M. Aaron, *Spate of New OCR HIPAA Enforcement Actions Confirms the Importance of (No Surprise!) Conducting a Thorough Risk Assessment and Prompt Breach Reporting* (Mar. 19, 2020), <https://www.lexology.com/library/detail.aspx?g=f473767f-e585-47d3-b2b9-2b85f25311a1>.
- 7 For more information on what is required in risk analysis, see Alex Masten, *Performing OCR-Quality Risk Analysis™*, Clearwater (May 13, 2020), <https://clearwatercompliance.com/blog/performing-ocr-quality-risk-analysis-on-new-systems-and-processes/>; *Performing OCR-Quality Risk Analysis in Expanding Telework and Telehealth Environments*, Clearwater On Demand Webinar (recorded Apr. 8, 2020), <https://clearwatercompliance.com/on-demand-videos/performing-ocr-quality-risk-analysis-in-expanding-telework-and-telehealth-environments-register/>.
- 8 <https://clearwatercompliance.com/irmpro/irmanalysis/>.
- 9 Jack O'Brien, *Following the COVID Surge: 5 Hospital Impacts*, Healthleaders (May 4, 2020), <https://www.healthleadersmedia.com/finance/following-covid-19-surge-5-hospital-impacts>.



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Defining Private Equity Transactions in Healthcare and Understanding Deal Options for Medical Groups

Mark Reiboldt, *Executive Vice President* | Coker Group
mreiboldt@cokergroup.com

Over the years, there have been numerous options for medical groups in considering different transaction types, structures, and valuations. At the same time, the actual types of partners that groups could consider for participating in a transaction also have expanded. As many practices have explored options with potential buyers other than hospitals, the number of deals where practices are selling to private equity (PE) firms (or PE-backed platform companies) has increased significantly.

These deals can often entail unique structures, terms, and outcomes; thus, it is important for those considering such transactions to be aware of and understand the various factors that can often be unique to PE transactions. Coker has published numerous articles on PE transactions with medical practices, but discussions with physicians and practice executives across the country have made clear that an important and distinctive question related to this topic is “what exactly is private equity?”

The presence of PE within the healthcare services industry is nothing new. But one thing we have found is that there is a rather broad reference in the term “private equity,” which has likely resulted in some confusion, or at the very least a lack of clarity, around what people actually mean when referring to PE deals.

People often use a number of monikers and categories of terms when referencing private equity. For the general concept of PE buyers, terms like investment banks, venture capital, hedge funds, investment funds, proprietary investors, merchant banks, institutional investors, etc. are often used. By the same token, people describing transactions or firms involved in transactions often refer to the parties involved as PE buyers, though what they are really talking about is a platform or operating company that is backed by PE capital. And while there is a significant amount of overlap in many of these different terms and references, there is little room for questioning how easy it is to be unclear about what exactly is going on in the overall discussion of PE investors, specifically within the healthcare services space.

In the simplest of explanations, PE firms are privately held (meaning they are not publicly traded investment firms) entities that manage capital raised from institutional investors, which is deployed into targeted markets, sectors, and business segments. PE firms acquire companies, which are typically also privately held. While there are cases where PE investors will expand their investment profile to

include the purchase of publicly traded securities and/or derivatives, this is beyond the scope of the discussion.

The primary, and in many cases singular, goal with these investments is to grow the businesses in a firm’s portfolio through organic and non-organic (i.e., add-on acquisitions) means, thus increasing the value of those assets over a period of time. And while expanding value over time can be an attractive investment strategy in its own right, the real return of value on an investment for PE firms is through an exit, of which there are generally two likely pathways: (1) a liquidity event where portfolio assets are sold to another buyer; or (2) a sale of such assets on the public market via an initial public offering (IPO) or similar vehicle. Again, this process varies, so this is a general explanation of what ultimately happens in these types of transactions. However, the discussion above covers the majority of what people are typically referring to when discussing PE investments, especially in entities such as medical practices.

More specifically, the following example illustrates the most typical scenario of PE transactions with medical groups.

A PE firm—let’s call them “ABC Capital”—manages a pool of capital from various institutional investors. ABC Capital’s focus is investing in healthcare services, and the firm’s leadership identifies medical practices as a primary opportunity for value in a market where there is ample room for growth and plenty of eager buyers for a future liquidity event. ABC Capital ultimately identifies a primary target in “AmeriMed,” which is a multi-specialty medical group consisting of 75 physicians across a certain geographic area of the United States that specializes in an effective mix of primary care and surgical sub-specialty medical services.

In a process consisting of significant time, effort, and compromise, which entails far more nuance than detailed in this high-level illustration, ABC Capital ultimately closes on a transaction to acquire and operate AmeriMed.¹ At this point, AmeriMed is the “platform investment” into this space on which ABC Capital will ultimately attempt to build and expand its value within this specific space.

Over the course of approximately five to seven years, ABC Capital will focus on two general objectives for this investment. First, ABC Capital will bring in the necessary personnel and operational and financial resources to maximize AmeriMed’s efficiency and profitability. Again, this is almost a laughable description of what actually goes

into this effort, but for the sake of this simple illustration, we will avoid getting into the weeds on what that process really entails.

Second, ABC Capital will work with AmeriMed's management to identify, pursue, and ultimately complete additional acquisitions of other attractive targets that can be incorporated into the platform. These add-on acquisitions are key to expanding the value, because optimizing the foundational entity and pursuing organic growth options can only go so far, not to mention the fact that such organic growth typically takes more time to achieve significant benchmarks. However, adding on other attractive entities to an efficient, well-functioning, and stable platform means that value is achieved in what can often be measured in exponential metrics, where acquired profits essentially drop to the bottom line of the core entity almost overnight.

Fast-forward five or so years down the road, after ABC Capital and AmeriMed have stabilized the platform and added earnings value through add-on acquisitions. At this point, ABC Capital is ready to explore how to achieve the maximum value potential on its original investment. This is where an exit or liquidity event comes into play, and ABC Capital will consider its options. As previously noted, there are a number of different ways this exit or liquidity event could ultimately play out, but for the sake of this basic example, let's assume that ABC Capital will consider selling the entire enterprise to another buyer, or selling the asset on the open, public markets through an IPO. While IPOs are not exactly rare, in the cases of PE-backed medical group entities, it is far more common for such assets to be sold to another party. And once again, there are many factors to consider and understand for these types of scenarios, but to keep the example simple, assume that AmeriMed—now much larger and representing a significantly greater value than when ABC Capital first acquired it—is sold to another buyer.

Who would be a likely buyer of AmeriMed in a case like this? It could be another PE firm, likely one that is larger than ABC Capital and that has existing assets in a similar space, where AmeriMed could be integrated with an existing platform. Other types of institutional investors also might be interested in the space, including hedge funds or publicly traded investment firms. Similarly, but with distinctive nuance, more of a strategic acquisition could occur, whereby AmeriMed is acquired by a large healthcare services entity, which could integrate the company in an existing operation. In some cases, we have even seen alternative types of strategic transactions occur where large hospital systems acquire such entities, integrating them within their established networks of medical services. And of course, there are many other possibilities, but those described above are a few of the more common examples in the current marketplace.

While the above example is general and admittedly oversimplified, it is intended to help illustrate some of the more common characteristics of what occurs when referring to private equity investors acting within the healthcare marketplace, specifically in relation to deals with medical practices. There are many additional details and varied considerations within each of the key elements discussed above. Coker has a wide range of content available that provides more in-depth discussions on many of these issues. But hopefully this article is a starting point to better understanding this unique and growing component of the healthcare marketplace for those considering—now or at some point down the road—the possibility of exploring opportunities with private equity.

Endnotes

1 For more information and resources on the structures, terms, and economic considerations involved in this process, see <https://cokergroup.com/>.

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Table of Contents

VOLUME I

DISPUTE RESOLUTION

- Arbitration
- Mediation

FRAUD AND ABUSE

- Fraud Compliance
- Government Investigations and Enforcement
- Internal Investigations
- Physician Compensation
- Stark Law

GOVERNANCE

- Board Operations
- Conflicts of Interest
- Corporate Responsibility Doctrine
- Executive Compensation
- Sarbanes Oxley

GOVERNMENT REIMBURSEMENT

- Medicare
- Medicaid

HEALTH CARE DELIVERY MODELS

- Accountable Care Organizations
- Medical Group Practices

HEALTH CARE FINANCE

HEALTH INFORMATION

- Big Data Issues
- Breach Notification
- Business Associates
- Electronic Health Records
- General Data Protection Regulations

VOLUME II

- HIPAA Privacy
- HITECH Act
- Medical Records Management & Operations
- Mobile Apps and New Technologies
- Telemedicine and Telehealth
- Vendor Agreements

VOLUME II

INDUSTRY TRANSACTIONS

- Acquisitions
- Affiliations and Joint Ventures
- Contracting
- Due Diligence
- Health Insurance Managed Care Contracts
- Licensure
- Real Estate
- Service Agreements

LABOR AND EMPLOYMENT

- Drug Testing
- Employment Policies
- Health Care Workforce & Staffing
- Immigration
- Physician Employment
- Sexual Harassment

VOLUME III

LIABILITY AND LITIGATION

- Crisis Communications
- Legal Services
- Risk Management

LIFE SCIENCES

- Clinical Trials
- Food and Drug Law
- Medical Research
- Secondary Use of Data

LONG TERM CARE

- Emergency Preparedness
- Facility Operations
- Patient Issues
- Staffing

MEDICAL STAFF

- Medical Staff Bylaws
- Peer Review & Disciplinary Proceedings

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Is 75th Percentile Compensation Safe? A Look at the New Definition of FMV and Its Applicability to Survey Data

Joe Aguilar, MBA, MPH, MSN, CVA, Partner | HMS Valuation Partners

Joe.Aguilar@HMSValue.com

Natalie Bell, MBA, CVA, Director | HMS Valuation Partners

Natalie.Bell@HMSValue.com

Rob Holland, MBA, MPH, CVA, Director | HMS Valuation Partners

Rob.Holland@HMSValue.com

Connor Melancon, MBA, Valuation Analyst | HMS Valuation Partners

Connor.Melancon@HMSValue.com

Amidst the backdrop of an already competitive and highly regulated environment, health systems are facing challenges from the convergence of the coronavirus pandemic, the new final rules under the Stark Law and Anti-Kickback Statute (AKS), and the financial impact from the 2021 Medicare physician fee schedule (Medicare PFS). Within this context, the number of healthcare transactions is expected to rise and return to pre-pandemic levels in 2021.¹ This means compliance teams will have to manage an increasing number of transactions, including but not limited to acquisitions, professional services arrangements, and physician employment agreements. As part of the compliance process, many of these transactions will be reviewed against compensation thresholds to establish fair market value (FMV) support. Given the importance of FMV to satisfying exceptions and navigating safe harbors, the determination of these compensation thresholds is of utmost importance.²

To establish these FMV thresholds, many health systems have relied on compensation survey data at particular percentiles. The 75th percentile is a common threshold used. However, is a single FMV threshold at the 75th percentile relevant and comparable to all subject transactions within the health system? It depends. The anticipated increase in transaction activity coupled with new regulatory guidance presents a good opportunity for compliance teams to delve into this question and re-evaluate their FMV process. Specifically, this piece will examine the definition of FMV as stipulated in the final rule, review the applicability of survey data at the 75th percentile based on the subject transaction, and provide recommendations for the appropriate use of surveys in deriving FMV.

Redefining FMV to Be Specific to the Subject Agreement

The term fair market value has been statutorily defined in Section 1877 (h)(3) of the Social Security Act. This definition has been incorporated into the regulations³ with various modifications through the years to increase clarity. Despite the Centers for Medicare & Medicaid Services' (CMS') attempts to clarify the definition of FMV, health systems and compliance teams have still been left with questions and ambiguity surrounding the determination of FMV and its application to transactions.

On November 20, 2020, CMS announced the new final rules under the Physician Self-Referral "Stark" Law and AKS in an attempt to modernize the regulations and remove "unnecessary obstacles" to value-based arrangements.⁴ Within these rules, CMS redefined FMV to be the value in an arm's-length transaction, consistent with the general market value of the subject transaction. With respect to compensation for services, general market value is now defined as the compensation that would be paid at the time the parties enter into the service arrangement as the result of bona fide bargaining between well-informed parties that are not otherwise in a position to generate business for each other.⁵

In redefining FMV, CMS provided some useful commentary and insight into its thoughts on determining the FMV range for a transaction.

- "We continue to believe the fair market value of a transaction—and particularly, compensation for physician services—may not always align with published valuation data compilations, such as salary surveys. In other words, the rate of compensation set

forth in a salary survey may not always be identical to the worth of a particular physician's services."

- "It is not CMS policy that salary surveys necessarily provide an accurate determination of fair market value in all cases. . . . Consulting salary schedules or other hypothetical data is an appropriate starting point in the determination of fair market value, and in many cases, it may be all that is required. . . . In our view, each compensation arrangement is different and must be evaluated based on its unique factors." As an example, CMS indicated that securing a sought after physician with a unique skillset may warrant a compensation level higher than typically expected for the specialty in the particular geographic area. On the flip side, hospitals that may be in a more tenuous economic state need not feel compelled to pay higher than financially prudent simply because salary surveys would suggest such a payment.
- For these reasons, CMS declined to establish a bright line rule based on a particular survey percentile. Specifically, CMS' policy of determining appropriate compensation is not based on salary data at or below the 75th percentile, nor is it outside of FMV range for compensation set above the 75th percentile.

So, Is 75th Percentile Safe? It Depends.

The concepts of validity and reliability in statistics may help answer the question. When reviewing compensation transactions, validity pertains to the extent to which the survey data is relevant to the subject transaction and reliability reflects the consistency of the results. While survey data provides valuable information, the appropriate application to each subject transaction is crucial. The importance of reviewing each transaction in the context of its unique factors is affirmed in CMS' commentary above and consistent with the standards of valuation practice.⁶

To assess the validity and reliability of utilizing the 75th percentile as a compensation threshold for FMV, compensation data from the

Medical Group Management Association (MGMA) 2020 Provider Compensation Survey⁷ was analyzed. The analysis herein will review the relationship between compensation, production levels, and various transaction defining categories as reported in the survey.

First, national compensation data will be reviewed utilizing a pay to production plotter that illustrates each physician's compensation along with their respective productivity in terms of Work Relative Value Units (wRVUs) and professional collections.⁸ Rather than reviewing compensation or productivity metrics in isolation, this graphical representation will show physicians at the same compensation level yet generating widely variable production levels.

Second, compensation data will be isolated based on the following factors: (1) compensation term, (2) geographic region, (3) service area population size, and (4) use of advanced practice providers. Compensation levels within each of these categories were then compared against each other as well as against the national data set. The greater the variability found through parsing out the data into different subsets, the less relevant a universal 75th percentile threshold is in determining FMV for a specific transaction.

Compensation to Production Plotter—Variances in wRVUs and Professional Collections

Production performance has been a widely accepted correlate to physician compensation. In fact, most physician compensation plans contain a production-based component.⁹ Even as health systems begin to shift their compensation design away from production toward value-based arrangements, production performance will continue to be a material driver in physician compensation. To what extent does a physician's wRVUs or professional collections drive compensation in the surveys?

To answer this question, note Figures 1 through 3.¹⁰ These figures illustrate physician compensation to wRVU production on a plotter graph for family medicine, non-invasive cardiology, and general surgery.

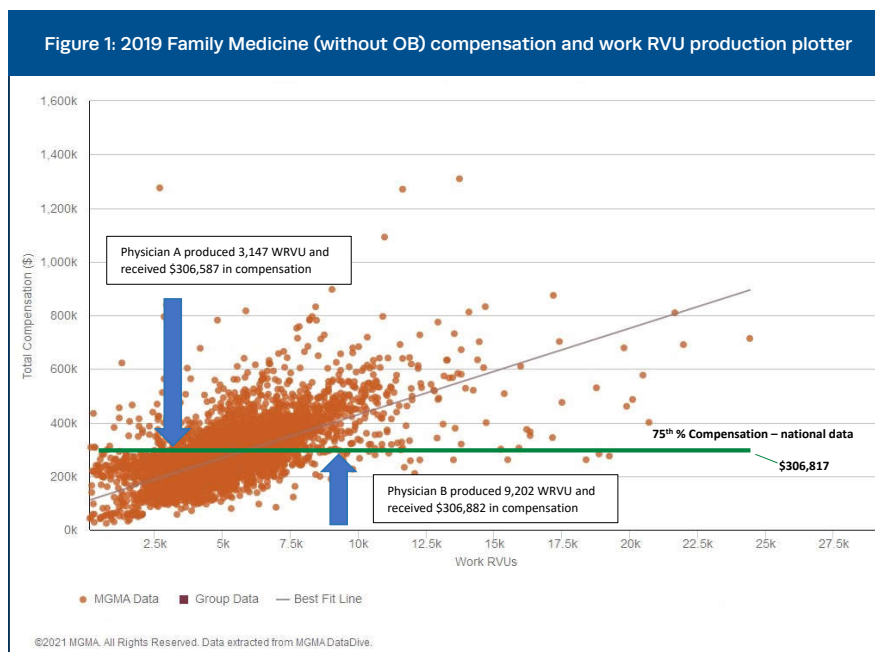


Figure 2: 2019 Cardiology: Non-Invasive compensation and work RVU production plotter

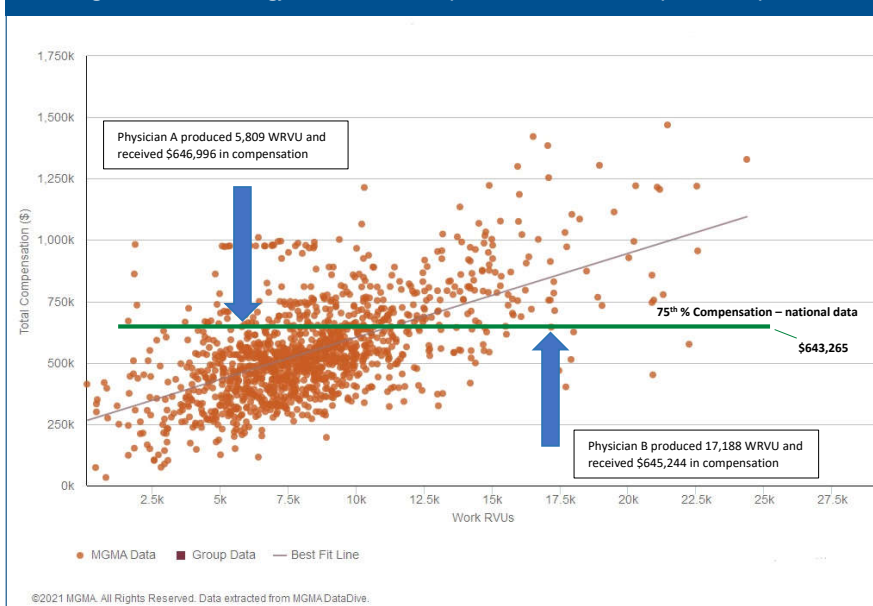


Figure 3: 2019 Surgery: General compensation and work RVU production plotter



Each point represents a specific physician's compensation and their corresponding wRVUs.¹¹ Note the variability in wRVU production across the graphs for each specialty along with a line corresponding to 75th percentile compensation. Specifically, the figures highlight a particular data point as Physician A and a second data point as Physi-

cian B.¹² Table 1 provides the variance in terms of wRVU production for each physician within each specialty. The difference in level of production between Physician A and Physician B is significant with Physician B generating approximately three times that of Physician A, yet both are compensated at approximately the 75th percentile.

Table 1: 75th percentile compensation based on wRVU production

Physician Specialty	Physician A wRVU Production ¹	Physician B wRVU Production ²	Variance
Family Medicine	3,147	9,202	6,055
Non-Invasive Cardiology	5,809	17,188	11,379
General Surgery	4,147	12,303	8,156

Note: 1. Represents 1 standard deviation below from the best-fit line generated by the linear regression.
2. Represents 1 standard deviation above from the best-fit line generated by the linear regression.

Table 2: 75th percentile compensation based on professional collections

Physician Specialty	Physician A Professional Collections ¹	Physician B Professional Collections ²	Variance
Family Medicine	\$188,265	\$1,023,588	\$835,323
Non-Invasive Cardiology	\$322,083	\$1,527,521	\$1,205,438
General Surgery	\$295,235	\$1,156,975	\$861,740

Note: 1. Represents 1 standard deviation below from the best-fit line generated by the linear regression.
2. Represents 1 standard deviation above from the best-fit line generated by the linear regression.

Table 3: 75th percentile compensation based on compensation terms

Physician Specialty	100% Salary Compensation	50% or more Salary plus Quality Bonus	100% Production Compensation	Total Physician Sample
Family Medicine	\$283,648 (n=2,105)	\$296,169 (n=1,364)	\$310,417 (n=844)	\$306,817 (n=8,848)
Non-Invasive Cardiology	\$585,250 (n=394)	\$635,267 (n=294)	\$620,031 (n=67)	\$643,265 (n=1,642)
General Surgery	\$500,001 (n=447)	\$574,209 (n=321)	\$584,908 (n=134)	\$545,961 (n=2,078)

Similar data can be found when using professional collections as the productivity metric versus wRVUs. In Table 2, notice the wide range of professional collections under each specialty for those physicians compensated at approximately the 75th percentile.

This production level variance would suggest that there are potentially unique circumstances, specific agreement terms, and/or particular physician characteristics for each of those subject transactions that impact value and yield 75th percentile compensation. The next sections will explore other differentiating metrics like compensation terms, geographic region, service area population size, and use of advanced practice providers (APPs).

Compensation Terms—Salary vs. Production-Based

Compensation terms can vary widely amongst physician transactions and will continue along this trend with the increase in value-based arrangements. However, for the purpose of this analysis, we are using the following compensation term categories set by MGMA: 100% salary compensation, 50% or more salary plus quality bonus, and 100% production compensation.¹³

Table 3 reflects the 75th percentile physician compensation based on compensation terms.

Table 4: 75th Percentile compensation based on geographic region

Physician Specialty	Eastern	Midwest	Southern	Western	Total Physician Sample
Family Medicine	\$288,939 (n=1,212)	\$301,059 (n=3,028)	\$323,338 (n=2,151)	\$310,332 (n=2,457)	\$306,817 (n=8,848)
Non-Invasive Cardiology	\$571,493 (n=571)	\$665,111 (n=468)	\$720,455 (n=369)	\$585,250 (n=234)	\$643,265 (n=1,642)
General Surgery	\$482,000 (n=367)	\$593,738 (n=660)	\$559,159 (n=582)	\$518,294 (n=469)	\$545,961 (n=2,078)

Table 5: 75th Percentile compensation based on service area population size

Physician Specialty	Nonmetropolitan Area: 49,999 or fewer	Metropolitan Area: 50,000 to 249,999 in population	Metropolitan Area: 250,000 to 999,999 in population	Metropolitan Area: 1,000,000 or more in population	Total Physician Sample
Family Medicine	\$299,708 (n=320)	\$306,888 (n=1,028)	\$319,863 (n=2,135)	\$303,803 (n=5,195)	\$306,817 (n=8,848)
Non-Invasive Cardiology	\$559,208 (n=28)	\$625,256 (n=224)	\$629,192 (n=421)	\$662,977 (n=949)	\$643,265 (n=1,642)
General Surgery	\$516,586 (n=108)	\$557,401 (n=368)	\$565,795 (n=484)	\$538,616 (n=1,050)	\$545,961 (n=2,078)

Table 6: 75th Percentile compensation based on use of advanced practice providers

Physician Specialty	Physician only	Fewer than 1 APP per Physician	1 or More APPs per Physician	Total Physician Sample
Family Medicine	\$284,747 (n=431)	\$309,444 (n=7,477)	\$303,661 (n=637)	\$306,817 (n=8,848)
Non-Invasive Cardiology	\$549,976 (n=80)	\$663,391 (n=1,313)	\$592,875 (n=190)	\$643,265 (n=1,642)
General Surgery	\$537,941 (n=224)	\$552,655 (n=1,588)	\$558,216 (n=180)	\$545,961 (n=2,078)

Table 3 illustrates a significant variance as you move along the continuum from 100% salary compensation to 100% production compensation, with physicians who are salaried receiving between 5% and 15% less than their counterparts whose compensation are based on production only.

In isolation, the variances shown on Table 3 would suggest that the specific compensation terms for the subject transaction shapes the resultant compensation at the 75th percentile. In other words, health systems may need to consider compensation terms and their impact on their overall FMV analysis for the subject transaction.

Geographic Region

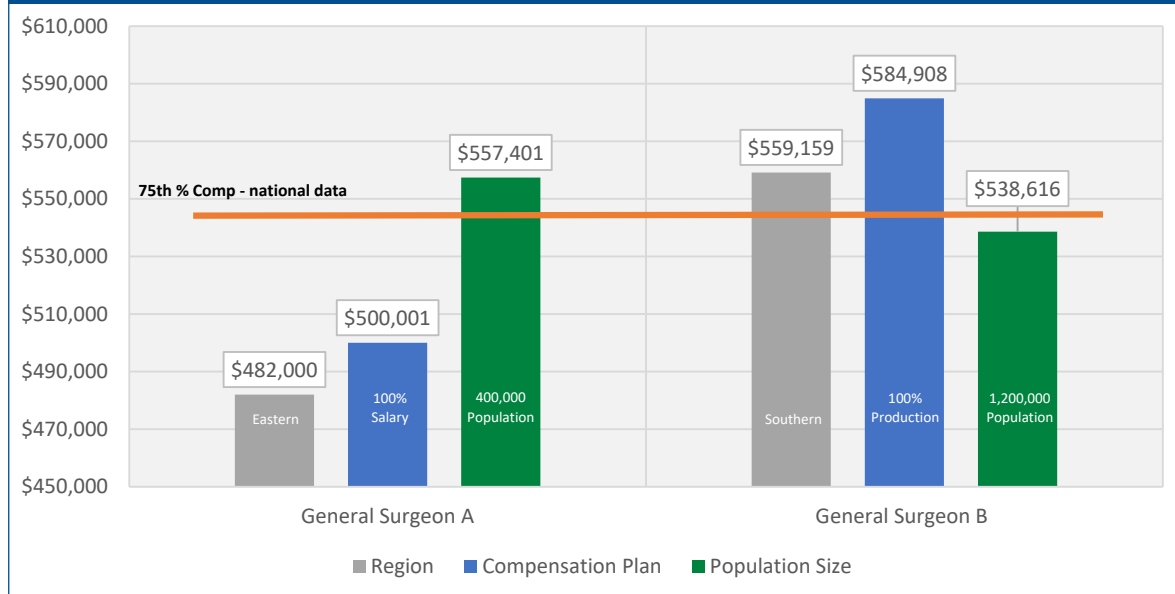
The economics of physician compensation in terms of operating expenses, reimbursement, and physician supply varies by geographic location. As such, health systems utilizing the 75th percentile compensation for the purposes of determining FMV should consider

adjusting the data for any differences specific to the practice's geographic location. Using national data could result in a material difference above or below the regional data. For the purposes of this analysis, the following regions were utilized based on MGMA: Eastern, Midwest, Southern, and Western.¹⁴

Table 4 reflects the 75th percentile physician compensation based on geographic region.

While some specialties may not have as significant of a swing across regions, others may. For instance, non-invasive cardiology shows a variance of approximately 25% from the region with the lowest compensation to the region with the highest. Caution should be taken, however, as data gets parsed even further down to the state level. Not only can the sample size drop to a level that would question its statistical significance, particular cities with higher than average compensation may begin to have a greater impact on the statewide figures (i.e. New York City MSA data versus the state of New York).

Figure 4: Comparison between 2 physician transactions and the 75th percentile MGMA compensation national data



Service Area Population Size

Determining physician compensation based on the population size in their service area is complex and multi-factorial. Challenges to recruitment, cost of living, proximity to services, etc. are but a few of the service area factors to consider when determining the FMV for a physician compensation transaction. For the purposes of this analysis, the following population sizes were utilized based on MGMA¹⁵: nonmetropolitan area (population of 49,999 or fewer), metropolitan area (population of 50,000 to 249,999), metropolitan area (population of 250,000 to 999,999), and metropolitan area (population of 1,000,000 or more).

Table 5 reflects the 75th percentile physician compensation based on service area population size.

The data in Table 5 does not show a significant change in physician compensation at the 75th percentile based solely on the population size, except for non-invasive cardiology. However, it should be noted that the variance is largely due to the compensation reported by only 28 physicians located in a nonmetropolitan area. A sample size at this level may not be statistically significant.

In addition, the compensation data alone may not tell the full story. For instance, physicians reporting in a nonmetropolitan service area reported wRVUs at approximately 10% lower than physicians in service areas with a higher population. This resulted in a higher compensation to wRVU rate for those physicians in the nonmetropolitan services area. Physicians in the nonmetropolitan service areas may also be more likely to cover a greater number of days on emergency room call or perform additional administrative services. As such, it is imperative that health systems review these nuances to the subject transaction when trying to determine FMV.

Use of Advanced Practice Providers

APPs are increasing in number within the U.S. healthcare system and are commonly used across most specialties.¹⁶ The pandemic has resulted in expanded regulatory flexibility surrounding the use of APPs in terms of required physician supervision, reimbursement, and scope of practice.^{17,18} For the purposes of this analysis, the following MGMA¹⁹ categories were used regarding APP utilization: physician only, fewer than one APP per physician, and one or more APPs per physician.

Table 6 reflects the 75th percentile physician compensation based on use of APPs.

The data in Table 6 shows a general trend toward increased compensation for physicians in practices that utilize APPs versus those relying only on physicians. Physician transactions including compensation for APP supervision are material to determining FMV for the subject transaction. Care should be taken when considering the value of the supervision with respect to a multitude of factors including, but not limited to, the ability to stack supervision compensation on top of a physician's base guarantee as well as the impact of APP utilization on eligible wRVUs for a physician's production bonus.

Combining Multiple Factors and Impact on Physician Compensation

Tables 1-6 isolated the impact to physician compensation based on various categories separately. Many of the surveys will contain other characteristics such as years in practice, ownership type, or annual hours worked. When reviewing an actual subject transaction, the unique factors that set the transaction apart will often include multiple components that will influence the FMV results. For example, Figure 4 illustrates the 75th percentile compensation for two distinct physician transactions.

The figure highlights the 75th percentile compensation for General Surgery based on the national data. The health system employing General Surgeon A based on 100% salary is in a city located in the eastern region of the United States with a population size of 240,000. The health system employing General Surgeon B based on 100% production is in a city located in the southern region of the United States with a population size of 1,200,000. Reviewing the 75th percentile compensation based on region, compensation plan, and population size in isolation shows that the health system employing General Surgeon A may overstate FMV if they rely solely on the 75th percentile compensation from national data. Whereas the health system employing General Surgeon B may understate FMV if they rely on the national data only. As a result, this underscores the need for health systems to not solely rely on national data, but to consider the relative impact from the facts and circumstance of each subject transaction.

Recommendations for Rethinking Use of Surveys in the FMV Process

The analyses above are illustrative of the importance of understanding the appropriate application of survey data. To mitigate FMV compliance risk, it is recommended that compliance teams consider using surveys as a starting point in the analysis, contemplate using multiple surveys, and analyze factors that may impact the comparability of the survey data.

Use Surveys as a Starting Point in the Analysis

The use of surveys has been and continues to be an integral part of establishing FMV. The variances shown do not disqualify the use of survey data as a legitimate source in determining FMV but emphasize the importance of using it within the context of the subject transaction. Recall the CMS commentary regarding the importance of “evaluating each transaction based on its unique factors” along with the fact that FMV should not be set at or below a particular survey percentile.

From these comments, CMS’ intention is clear in stating that a particular survey percentile does not reflect FMV. Although the Stark Law provided for a brief period an hourly rate threshold as a safe harbor for FMV, this comment provides health systems the flexibility to compensate above particular percentiles if the subject transaction warrants it through the FMV process.

The FMV process should analyze the transaction and review the survey data within the context of the subject transaction. Some unique factors to consider are as follows:

- a. Compensation terms
 - » What portion of the compensation is based on salary, production, quality, emergency call, graduate medical education, etc.?
- b. Provider-specific characteristics
 - » Are there factors that separate out this physician from her peers (i.e. training, skillset, and thought leadership)?
- c. Position-specific requirements
 - » What is needed of the physician to fulfill the requirements of the position (i.e. hours worked, student teaching, and nights/weekends)?
- d. Geographic-specific factors
 - » What are the local geographic circumstances where the physician will practice that may influence value (i.e. cost of living, housing market, school systems, and the availability of other services)?
- e. Employer considerations
 - » Will the transaction include a value-based arrangement and is it commercially reasonable given the size, scope, and specialty involved?

Reviewing each transaction through the lens of the influencing categories above will have the greatest chance of leading to a valid and reliable FMV result.

Contemplate Using Multiple Surveys

While many health systems use one survey for their internal FMV process, the use of multiple surveys may provide a larger sample size for benchmarking as well as potentially more comparable data relevant to the subject transaction. This is consistent with CMS’ statement on “[referencing] multiple, objective, independently published salary surveys [as] a prudent practice for evaluating fair market value.”²⁰

It is important, however, for health systems to understand some of the differences between the surveys that may involve how compensation and other metrics are defined as well as the variability regarding the characteristics of the physician respondents in terms of practice ownership, degree of academic practice, single versus multi-specialty practice, and/or practice group size. For instance, in terms of group size, 88% of the physician groups that reported to the 2020 MGMA Provider Compensation survey were comprised of ten physician FTEs or less,²¹ while 74% of the physician groups that reported to the American Medical Group Association (AMGA) 2020 Medical Group Compensation and Productivity Survey²² consisted of 151 or more physician FTEs. As for SullivanCotter’s 2020 Physician Compensation and Productivity Survey Report, 62% of the respondents had an academic affiliation,²³ when compared to only approximately 20% of the respondents to MGMA in 2020.

As a result, utilizing multiple surveys appropriately may increase the applicability of the benchmark data to the subject transaction.

Analyze Factors That May Impact the Comparability of the Survey Data

Year-over-year changes to compensation, wRVUs, collections, and other metrics within the surveys do occur with varying degrees of significance. Policy changes can occur that impact some or many of the metrics reported in the surveys for a particular specialty. For instance,

- a. *COVID-19 pandemic*—The challenges associated with the pandemic will have a material impact on surveys published in 2021. Specifically, patient volumes fluctuated in 2020 associated with, but not limited to, the stay at-home orders, telehealth services, and restrictions on elective surgeries. As a result, this may have a disproportionate impact on wRVUs versus physician compensation to the extent that health systems and physician practices continued to maintain the same level of physician compensation. In addition, collections reported for 2020 may also be impacted by the pandemic relief programs targeting

health systems and physician practices. All of these factors will affect benchmark metrics including total compensation, wRVUs, and collections as well as the resultant comp:wRVU and comp:collection ratios.

- b. *2021 Medicare PFS*—The 2021 Medicare PFS changes will have a significant impact on the comparability to surveys this year and into next. Specifically, wRVU values for office and other outpatient services evaluation & management codes have increased by 7% to 13% amongst new patient office visit codes 99202-99205 and by 28% to 46% amongst established patient office visit codes 99212-99215.²⁴ For health systems utilizing the 2021 Medicare PFS, the calculated 2021 wRVUs will not be comparable to wRVUs reported in the 2021 surveys based on 2020 data. Collections will also be impacted at a lesser rate based on the 3.3% decrease to the Medicare conversion factor as well as each physician practice's procedure code volume and payor mix.²⁵
- c. *Specialty-specific market changes*—Other isolated changes to particular specialties have occurred through the years. Cardiology represents one example of a significant shift within a specific specialty. With the reduction in reimbursement for in-office imaging services in 2005 from the Deficit Reduction Act, a significant shift ensued away from private practice. Private practice cardiologists represented 73% of the total in 1998 before dropping to 23% just 20 years later.²⁶ This shift to employment resulted in a steady overall increase in cardiology compensation reported in the surveys.²⁷ A more recent example can be seen in the change in endoscopic sinus surgery (ESS) codes that were bundled in the 2018 Medicare PFS. This resulted in a drop in collections ranging from -7.9% to -23.6%.²⁸ These examples illustrate the fact that market forces specific to certain specialties need to be accounted for year over year.

For the purposes of ensuring comparability, compliance teams may need to normalize the subject transaction data and/or benchmark against multiple survey years. The methods used to normalize the data will vary dependent on the specific circumstances impacting the benchmark data for the subject transaction.

Conclusion

Given the volume of transactions along with the continued importance of the compensation surveys, health systems will continue to utilize survey data in establishing protocols and determining their internal FMV compliance processes. In doing so, compliance teams should not only consider survey data at particular percentiles, but the FMV process itself by which each subject transaction is analyzed and benchmarked against those surveys. In short, this process should be comprehensive and consistent.

Compliance teams should document each subject transaction's compensation terms, provider-specific characteristics, position-specific requirements, geographic-specific factors, and any other employer considerations. These unique factors will inform the quantitative analysis and result in utilizing the appropriate survey data for benchmarking purposes.

The FMV process requires consistency across transactions in order to increase the reliability and validity of the results. These steps should be

written as policy identifying the steps to take in determining FMV. Any departures from the normal process should highlight the distinguishing characteristics of the physician or transaction that warrants the deviation.

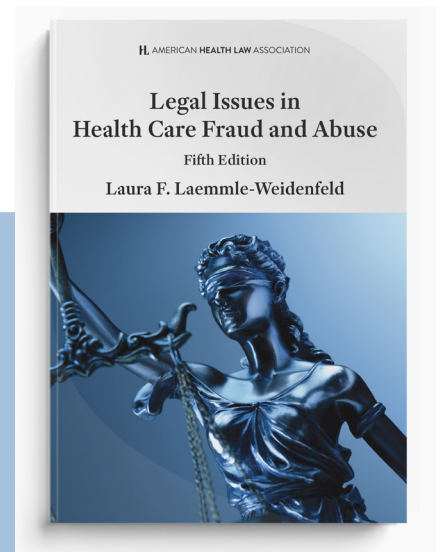
So, choosing the 75th percentile compensation as the FMV compensation threshold is potentially possible, however, it needs to be contextualized by the subject agreement, supported through a relevant and comparable benchmark analysis, and documented accordingly.

Endnotes

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- 2 We recognize the importance of establishing commercial reasonableness when evaluating value-based arrangements, however, the scope for this piece is establishing FMV and will be the focus of the analyses in this article.
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- 4 83 Fed. Reg. 29524.
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- 7 2020 MGMA DataDive Provider Compensation based on 2019 data. This survey was chosen because of its wide use amongst health systems and the ability to breakdown data by specific categories. It is important to note that this data is based on reporting from 2019 prior to the impact of the pandemic.
- 8 Only physicians who reported both compensation and wRVUs/professional collections are reflected in the plotter graph.
- 9 2020 MGMA DataDive Provider Compensation based on 2019 data.
- 10 Data republished with permission. © 2021 MGMA. All rights reserved. www.mgma.com/data.
- 11 For this analysis, we are assuming that all reported compensation for each physician is within FMV.
- 12 To standardize the analysis, the physician data points chosen along the 75th percentile compensation were based on one standard deviation above and below the best-fit line as determined by linear regression.
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Table of Contents

- 1 The Fraud Enforcers: Who Are They and What Do They Do?
- 2 Federal Anti-Kickback Laws
- 3 Federal Physician Self-Referral Prohibitions
- 4 Administrative Sanctions Available to Federal Enforcers
- 5 The False Claims Act and Other Means of Federal Enforcement of Health Care Fraud and Abuse Laws
- 6 State and Private Initiatives to Combat Fraud
- 7 Compliance and Self-Reporting

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Fair Market Value and Commercial Reasonableness—2021 and Beyond

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This article is intended to highlight some of the most noteworthy revisions, clarifications, and modifications provided by the Centers for Medicare & Medicaid Services (CMS) through the Stark Law Final Rule and by the Office of Inspector General (OIG) through the Anti-Kickback Statute (AKS) Final Rule. HSG is not a law firm; we are a health care consulting and compensation valuation firm, so this article is not an exhaustive legal interpretation, summary, or review of all of CMS and OIG's updates, but rather a review of selected areas—particularly those elements and areas we view as having the most impact in the world of physician and advance practice provider (APP) compensation and transactions valuation. This piece concludes with thoughts regarding the COVID-19 pandemic's effect on the immediate future of physician and APP compensation valuation.

The Stark Law and Anti-Kickback Statute

On November 20, 2020, the U.S. Department of Health and Human Services (HHS) published Final Rules for the Physician Self-Referral Law (Stark Law), the federal AKS, and the Civil Monetary Penalties (CMP) Law. These new rules, which significantly amend the existing laws, are a direct result of HHS' Regulatory Sprint to Coordinated Care. HHS, through the Regulatory Sprint to Coordinated Care, has a stated goal of reducing regulatory barriers within our nation's health care system and accelerating "the transformation of the health care system into one that better pays for value and promotes care coordination." As HHS' statement indicates, value-based arrangements and transactions are the focus of this episode of Stark Law and AKS revisions, but other areas and central ideas of the Stark Law and AKS are significantly impacted as well.

On December 2, 2020, OIG published its Final Rule, "Revisions to the Safe Harbors Under the Anti-Kickback Statute and Rules Regarding Beneficiary Inducements," and CMS published its Final Rule, "Modernizing and Clarifying the Physician Self-Referral Regulations" in the *Federal Register*.

The Stark and AKS Final Rules became effective January 19, 2021, with the exception of certain changes to the definition of a "group practice" that have an effective date of January 1, 2022 to give physician practices time to adjust their compensation methodologies.

The AKS Final Rule creates new safe harbors for entities participating in a "value-based enterprise" (VBE) and amends existing safe harbors. OIG's proposed new safe harbors are:

- » Three new safe harbors for remuneration exchanged between or among participants in value-based arrangements:
 - o Value-based arrangements with full financial risk.
 - o Value-based arrangements with substantial downside financial risk (at least 5%).
 - o Care coordination arrangements to improve quality, health outcomes, and efficiency without requiring the parties to assume any financial risk.
- » Arrangements for patient engagement and support to improve quality, health outcomes, and efficiency. This safe harbor permits patient engagement tools and/or other support furnished directly by a VBE to a patient in a target patient population that are directly connected to the coordination and management of care.
- » CMS-sponsored model arrangements and CMS-sponsored model patient incentives. This safe harbor is intended to provide greater predictability for model participants and uniformity across models.
- » Cybersecurity technology and services safe harbor for remuneration in the form of cybersecurity technology and services. This safe harbor is designed to facilitate improved cybersecurity in health care through donations of cybersecurity technology and services.

Additionally, OIG is finalizing changes to the following existing safe harbors:

- » Electronic health records (EHR) safe harbor updates and removes provisions regarding interoperability; removes the December 31, 2021 sunset provision and prohibition on donation of equivalent technology; and clarifies protections for cybersecurity technology and services included in an EHR arrangement.

- » Personal services and management contracts and outcomes-based payments safe harbor creates protection under safe harbor for part-time or intermittent arrangements and arrangements for which total compensation is not known in advance—it eliminates a requirement that part-time arrangements have a schedule of services specifically set out in advance in the agreement.
- » Warranties safe harbor was modified to revise the definition of warranty and provide protection for bundled warranties for one or more items and related services provided they are paid for under the same payment.
- » Local transportation safe harbor was revised to expand mileage limits for rural areas (to 75 miles) and eliminate mileage limits for transporting patients discharged from the hospital to their home.
- » The AKS Final Rule further codifies statutory revisions by adding the statutory exception to remuneration related to Accountable Care Organization Beneficiary Incentive Programs for the Medicare Shared Savings Program. OIG also amended the definition of remuneration in the Beneficiary Inducements CMP statute to integrate a new statutory exception to the prohibition on beneficiary inducements for certain “telehealth technologies.”

CMS’ modifications and additions to the Stark Law rules were equally significant. CMS indicated that many of the changes to the Stark Law rules are intended to provide new flexibility and reduce administrative burden on health care organizations and providers in the structuring of arrangements, making it easier and less expensive to comply with the Stark Law. Below is a listing of some of the key changes:

- » Finalized new, permanent exceptions for value-based arrangements that will permit physicians and other health care providers to enter into value-based arrangements without fear that their legitimate activities to better coordinate care, improve quality, and lower costs would violate the Stark Law.
- » Provided additional guidance on key requirements of the exceptions to the Stark Law to make it easier for healthcare providers to take steps to ensure compliance, such as:
 - o Guidance on identifying compensation formulas that take into account the volume or value of a physician’s referrals.
 - o Guidance on reconciliation of payment variances.
- » Modified the rule related to profit sharing and productivity bonuses such that distribution of profits from designated health services directly attributable to a physician’s participation in a value-based arrangement are deemed not to take into account the volume or value of the physician’s referrals.
- » Finalized a new exception to protect compensation not exceeding an aggregate of \$5,000 per calendar year to a physician for the provision of items and services, without the need for a signed written agreement and compensation that

is set in advance if certain other conditions are met (i.e., fair market value and does not take into account volume and value of referrals).

- » Finalized protection for arrangements that will apply regardless of whether the parties operate in a fee-for-service or value-based payment system, such as donations of cybersecurity technology.
- » Reduced administrative burdens, such as:
 - o Providing additional flexibility related to signature and writing requirements.
 - o Eliminating the period of disallowance rules and correcting discrepancies during the arrangement.
 - o Modifying the definition of “set in advance” used in many Stark exceptions to allow modification of compensation during the term of an arrangement (including in the first year).

Salary Surveys

For those in the physician and APP compensation valuation arena, and for any hospital or health system that compensates a health care provider for administrative and/or professional services (which would be all hospitals and health systems in the country), there are other aspects of the Stark Law revisions that are of particular interest. These Stark Law updates may not alter the approach to production of a compensation fair market value and commercial reasonableness opinion (i.e., we are still going to consult industry salary surveys), but it certainly has us doubling down on the lengths to which we go to describe and document the uniqueness of a provider, the market, or the situation. In reading CMS’ comments in the *Federal Register*, there is no doubt that CMS views each case as unique and there is not a set formula or methodology for determining fair market value. Yes, consulting “multiple, objective, independently published salary surveys remains a prudent practice for evaluating fair market value,” as stated in Stark II, Phase III, but salary surveys are not automatic—regardless of the percentile at which the compensation in question falls.

According to CMS, “we continue to believe that the fair market value of a transaction—and particularly, compensation for physician services—may not always align with published valuation data compilations, such as salary surveys. In other words, the rate of compensation set forth in a salary survey may not always be identical to the worth of a particular physician’s services.” This is something that we have experienced from time to time for uniquely trained or experienced physicians and/or challenging markets, but more recently and frequently for Certified Registered Nurse Anesthetists (CRNAs) who practice autonomously—usually in rural markets. Often traditional salary survey sources do not provide datasets based on level of physician involvement or oversight for CRNAs, making it difficult to find an apples-to-apples comparison. This has required abandoning, or at least augmenting, traditional surveys with anesthesia-related job posting sites to find comparable salary offerings and ranges. This has also been true in markets in which the demand and competition for CRNAs has exploded. Traditional survey sources have proven to be

dated and inadequate for the CRNA salaries being offered. Again, job posting sites have been invaluable to determining fair market value for high-demand services. Note this requires a valuator being able to find enough comparable postings with posted salary offers—less than ten is typically not enough. CRNAs are only one example—the same challenges could easily apply to any physician specialty or market. This is the art and the work involved in determining fair market value. We also think this is an appropriate reflection and representation of what CMS recognized and articulated when it said: “It is not CMS policy that salary surveys necessarily provide an accurate determination of fair market value in all cases.”

“Floors” and “Ceilings”

Many hospitals and health systems across the country have drawn a line in the sand and set a base compensation threshold at the 75th percentile for physician compensation. If base or guaranteed compensation does not exceed the 75th percentile for the physician’s specialty, as published by a survey source like the Medical Group Management Association’s Provider Compensation Survey, then they do not seek a fair market value opinion because they consider the compensation to be fair market value. Others have been slightly more conservative and mandated in their physician contracts that they will not provide total compensation (base compensation plus all bonuses) above the 75th percentile (a true “ceiling”). According to CMS, some of the commenters on the Final Rule asserted that, “a ‘safe harbor’ based on a range of values in salary surveys would be consistent with what they stated was established CMS policy that compensation set at or below the 75th percentile in a salary schedule is appropriate and compensation set above the 75th percentile is suspect, if not presumed inappropriate.” To these comments CMS responded, “For the reasons explained in Phase I, Phase II, and Phase III, we decline to establish the rebuttable presumptions and ‘safe harbors’ requested by the commenters. We are uncertain why the commenters believe that it is CMS policy that compensation set at or below the 75th percentile in a salary schedule is always appropriate, and that compensation set above the 75th percentile is suspect, if not presumed inappropriate. The commenters are incorrect that this is CMS policy.” Clearly, from CMS’ perspective, both referenced policies are misguided. It is inaccurate for a hospital or health system to believe that just because base compensation is below the 75th percentile there is no risk and that the compensation they are providing is automatically fair market value. Likewise, a belief that paying a provider above the 75th percentile is not fair market value is also misplaced.

Via the Final Rule, CMS has also indicated that salary surveys, regardless of percentile, are not automatic determinates of fair market value, stating, “Consulting salary schedules or other hypothetical data is an appropriate starting point in the determination of fair market value, and in many cases, it may be all that is required. However, we agree with the commenter that asserted that a hospital may find it necessary to pay a physician above what is in the salary schedule, especially where there is a compelling need for the physician’s services.” Despite the request and urging of commenters, CMS declined to “establish rebuttable presumptions that compensation is fair market value or ‘safe harbors’ that would deem compensation to be fair market value if certain conditions are met.” Bottom line, CMS affirmed that

there is no guarantee to fair market value determination—there is no universal formula or proverbial rubberstamp as it pertains to provider compensation. Rather, each case must be evaluated and considered in the context of the situation. As CMS stated, “In our view, each compensation arrangement is different and must be evaluated based on its unique factors.” Virtually every provider compensation exception under the Stark Law requires that the compensation paid reflects fair market value. So, while it may require effort, and in some cases could be difficult to achieve, finding fair market value is a must. Not that CMS made it easy by providing a bright line or even a floor that would allow us to say, “if we go above this level, then we must get a formal thirty-party fair market value opinion.” According to CMS, “We wish to be perfectly clear that nothing in our commentary was intended to imply that an independent valuation is required for all compensation arrangements.”

What the Heck Is the “Big Three”?

Another key Stark Law change that will certainly influence fair market value and commercial reasonableness opinion approach and deliverable is the uncoupling or disentanglement of the “volume or value standard (and the other business generated standard)” from the definitions of fair market value and commercial reasonableness. As a result, fair market value, commercial reasonableness, and the volume or value standard are “separate and distinct requirements, each of which must be satisfied when included in an exception to the physician self-referral law.” CMS refers to these three “cornerstones” of the exceptions to the Stark Law as the “Big Three.” CMS redefined the Big Three as follows:

- » **Fair market value** means the value in an arm’s-length transaction, consistent with the general market value of the subject transaction.
- » **Commercially reasonable** means that the arrangement furthers a legitimate business purpose of the parties to the arrangement and is sensible, considering the characteristics of the parties, including their size, type, scope, and specialty.
- » **Volume or value standard and the other business generated standard** requires that the compensation paid under the arrangement is not determined in any manner that takes into account the volume or value of referrals by the physician who is a party to the arrangement, and some exceptions also include a requirement that the compensation is not determined in any manner that takes into account other business generated between the parties.

In addition to the general definition of fair market value above, CMS’ revisions to the Stark Law also provide definitions of fair market value that are specific to the rental of equipment and the rental of office space. The definitions are as follows:

- » With respect to the rental of equipment, fair market value means the value in an arm’s-length transaction of rental property for general commercial purposes (not taking into account its intended use), consistent with the general market value of the subject transaction.

- » With respect to the rental of office space, fair market value means the value in an arm's-length transaction of rental property for general commercial purposes (not taking into account its intended use), without adjustment to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor where the lessor is a potential source of patient referrals to the lessee, and consistent with the general market value of the subject transaction.

Central to the definition of fair market value is the definition of “general market value.” General market value is also restated in the Final Rule. Not only was the definition of general market value amended, but it was also given three unique definitions related to the context of a specific type of transaction. The three types of transactions are asset acquisition, compensation, and rental of equipment or office space. The general market value definitions are:

1. Assets. With respect to the purchase of an asset, the price that an asset would bring on the date of acquisition of the asset as the result of bona fide bargaining between a well-informed buyer and seller that are not otherwise in a position to generate business for each other.
2. Compensation. With respect to compensation for services, the compensation that would be paid at the time the parties enter into the service arrangement as the result of bona fide bargaining between well-informed parties that are not otherwise in a position to generate business for each other.
3. Rental of equipment or office space. With respect to the rental of equipment or the rental of office space, the price that rental property would bring at the time the parties enter into the rental arrangement as the result of bona fide bargaining between a well-informed lessor and lessee that are not otherwise in a position to generate business for each other.

What does it mean for a compensation arrangement to be commercially reasonable? The answer to that question has often been more elusive and not as immediately apparent as fair market value—and we know how nebulous and elusive fair market value can be at times. Unlike fair market value determination, commercial reasonableness is not as readily determined by standardized methodologies, practices, or sources. To determine what is commercially reasonable, we first must start with a basic definition. According to CMS in the Final Rule, “commercially reasonable means that the particular arrangement furthers a legitimate business purpose of the parties to the arrangement and is sensible, considering the characteristics of the parties, including their size, type, scope, and specialty.” In the Final Rule, CMS also reiterated that “the determination of commercial reasonableness is not one of valuation.” An arrangement can be fair market value, but that does not mean that it is commercially reasonable. On the other hand, an arrangement must be considered fair market value in order to be commercially reasonable. In a simple example, we can determine that fair market value for compensation of a medical director for a cardiac catheterization laboratory is \$150 per hour. That determination may be fairly conservative and well within a reasonable range, but if said physician is the second of two medical directors

for this service and the duties are already handled by the first medical director so the second is not needed, then the \$150 per hour medical directorship, while fair market value is not commercially reasonable.

As stated above in our discussion of fair market value, CMS continues to make it clear that the commercial reasonableness determination is also accomplished through consideration of an arrangement's context and from the perspective of those involved. According to CMS in the Final Rule, “We continue to believe that this determination should be made from the perspective of the particular parties involved in the arrangement.” Another key factor to commercial reasonableness is answering the question: Does the arrangement make sense to accomplish the parties' goals? Documenting the organization's goals with the arrangement or transaction must be a priority.

Losing Money

For the past 30 years, a key consideration for health care organizations entering into transactions and arrangements for the employment and compensation of physicians has been the profitability of the practices in which the physicians, their staff, and other practice-related resources are housed—or more precisely the losses of the practices in which physicians and APPs are housed. Many hospitals and health systems around the country have employed physicians and then struggled, or at least had to come to grips with the fact that, the practices are losing money. Their concern has been financial, yes, but also an increasing concern of compliance risk. Many organizations are frequently asking: Do we have greater compliance risk because our practices are losing money according to our internal financial statements and accounting? Do our losses mean the compensation we are paying, while fair market value, is not commercially reasonable? How can we lose so much money and still consider our arrangement commercially reasonable?

There are a myriad of reasons that hospital-owned practices lose money—higher practice costs, poor revenue cycle operations, mismatched compensation incentives, poor management, etc. Many of these reasons are out of the hospital or health system's control. For a vast number of health care entities, employment of physicians and APPs is the only option for attracting and maintaining providers in their community. HSG has written articles about practice losses and how to address them. That is a topic for another day. The fact is hospital-owned practices typically lose money—it is more the rule than the exception. Since the Stark Law was enacted in 1989 this been a compliance concern in the back of the minds of hospital executives. Through the Final Rule, CMS has addressed the topic of losses and profitability, stating “the determination that an arrangement is commercially reasonable does not turn on whether the arrangement is profitable; compensation arrangements that do not result in profit for one or more of the parties may nonetheless be commercially reasonable.” CMS offers several examples of reasons parties may enter into an arrangement or transaction despite financial “losses to one or more parties.” According to CMS, those reasons include, “community need, timely access to health care services, fulfillment of licensure or regulatory obligations, including those under the Emergency Medical Treatment and Labor Act, the provision of charity care, and the improvement of quality and health outcomes.” In our opinion,

this means health care organizations must go the extra mile to document their reason(s) for compensating physicians and APPs, if those arrangements and transactions are exhibiting or are expected to yield financial losses. Strategy, market growth, and larger referral bases were not among the examples. What are your reasons? What are your goals? These are two critical questions that must be answered. While CMS has indicated that the presence of losses does not automatically call into question an arrangement's commercial reasonableness, the agency noted that each arrangement or transaction's circumstances will ultimately determine its commercial reasonableness. We also believe there has to be a limit to what is reasonable in terms of losses. Referring to survey data regarding practice losses per physician and per provider can be enlightening. If a hospital is losing three times the national average in its employed primary care practice ask: (1) Why?; (2) How can it be fixed?; and (3) Does it mean the compensation is not commercially reasonable?

The COVID Impact

A factor that is certain to affect fair market value determination during the coming year is not new or revised legislation. Instead, it is the impact of the COVID-19 pandemic on the industry's salary and production survey data. The same survey data that many compensation valuers rely on as a central component to their fair market value analysis and opinion. Our hypothesis is that COVID-19 will appreciably affect the salary, production, and other data reported by physicians and their practices—in some instances, to a significant degree.

Specialties like critical care, hospital medicine, emergency medicine, and pulmonary medicine may have experienced increases in patient volume due to the pandemic. Some providers in these four specialties may have seen an increase in compensation to reflect their increased workload, while others, those paid salary and shift rates, may not have seen an increase in compensation. Office-based primary care has been significantly affected as offices were closed for a period of time and then had to adjust to telehealth and virtual visits. Proceduralists such as dermatologists, orthopedic surgeons, ophthalmologists, otolaryngologists, plastic surgeons, urologists, etc. have been significantly impacted by decreased patient volume. On the revenue side, many practices had the benefit of the Paycheck Protection Program, but unfortunately, for many that was not enough to outweigh the additional personal protective equipment cost and lost revenue due to decreased patient volume.

Bottom line, 2021 surveys, based on 2020 data, are likely going to be challenging. In some cases, the alignment between compensation and production may be distorted. Typical compensation per Work Relative Value Unit rates could be significantly off from traditional levels for given specialties. Ultimately, valuers likely will have to be creative and look back into past years' surveys to evaluate trends and validate current survey data. CMS has stated that compensation between certain percentiles does not provide a safe harbor. If ever there was a time in which that is true on so many levels, this is it. Grabbing a 2021 survey and finding a percentile might be enough, then again, it might not. There is no fair market value calculator that takes in a couple datapoints and spits out a positive or negative fair market value answer. Get ready and roll up your sleeves for the work ahead.

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Complex Challenges, Smart Solutions
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Ambulatory Real Estate Development: Converging Perspectives and Objectives Between Health Systems, Physicians, and Developers

Craig Flanagan, Vice President | Realty Trust Group, LLC
cflanagan@realtytrustgroup.com

Adam Luttrell, Vice President | Realty Trust Group, LLC
aluttrell@realtytrustgroup.com

For the past ten years, delivering healthcare to communities in non-acute care settings has become a central strategic objective for most health systems. The impetuses for shifting the delivery of healthcare to non-acute settings have been technology improvements in patient care, reimbursement and policy changes, and efforts to create lower-cost settings as part of the drive towards value-based healthcare. The importance of delivering healthcare in this setting has been magnified during the COVID-19 pandemic as the need for conservation of acute care space to provide emergency-based care has been amplified.

Successfully completing a large-scale ambulatory real estate development project requires aligning the strategic goals, concerns, and values of three primary stakeholders: a sponsoring hospital or health system, physicians and other providers, and a real estate developer. This article provides insight into the perspectives and objectives that each of these stakeholders brings into a development project and dissects the areas in which each stakeholder's priorities align and differ. Understanding the objectives and concerns of the three stakeholders and finding ways to bridge the gaps when they have conflicting interests is critically important to ensuring that the development project is ultimately a success. Healthcare real estate advisory and development firms are uniquely qualified to help efficiently and effectively bridge these gaps because of their experience working with each type of stakeholder.

Realty Trust Group, LLC (RTG) is a healthcare real estate advisory and development firm with significant experience spanning the course of over 20 years working with health systems and physicians to craft and implement real estate strategies and develop medical office buildings and other ambulatory care facilities—RTG actively manages over 14.5 million square feet of healthcare real estate, has completed over \$2.2 billion of healthcare real estate transactions, and has delivered over \$736 million in development projects.

To more effectively illustrate the key steps in developing an ambulatory real estate project and to discuss how health systems, physicians, and developers can align their perspectives and objectives on any given development, this article walks through a hypothetical scenario

where a multi-hospital health system (the “Hospital”) and a healthcare-focused real estate developer (the “Developer”) are working together on an ambulatory medical office building development, with the anticipation of recruiting physicians to participate in the development. While the hypothetical will present certain stages of the development process in a linear fashion, it is important to note that many of these stages will happen concurrently during development.

The Hypothetical

After an extensive period of strategic planning, the Hospital has identified a geographic submarket desirable to expand their delivery of care through the development of a medical office building focused on ambulatory services. The project would comprise approximately 150,000 square feet of space for both hospital services and third-party physicians. The Hospital evaluated various project delivery options and elected to utilize the expertise of a healthcare-focused real estate developer. To preserve the integrity of the medical services to the patient population and maintain a certain level of control over the project, the Hospital requires owning the land that would be developed so that it can impose certain restrictions and controls on the use of the building through a long-term (>50 years) ground lease. The Hospital will also enter into a master lease with the Developer to lease a large portion of the space in the building and may sublease portions of the space to third-party tenants. The estimated project costs are \$45,000,000.

The Developer will source the requisite financing and own the building. Additionally, to accelerate the leasing effort prior to the completion of the development, the Developer will offer equity participation in the ownership of the project to physicians who are willing to enter into leases at the building for a term of at least ten years. The Developer will source construction financing that will consist of 70% debt and 30% equity and, upon completion and subsequent stabilization at 95% occupancy of the development, the Developer will source permanent financing, thereby creating an equity event for the investors.

In this hypothetical, and in most healthcare real estate projects, the primary considerations are:

1. Site Selection;
2. Entitlements;
3. Planning and Design;
4. Ownership Structure;
5. Restrictions;
6. Capital and Financing;
7. Leasing; and
8. Operations.

1. Site Selection

After the Hospital completes its internal analysis regarding the desired delivery of services and the general location where these services are needed (typically driven by internal data related to patients and services and external data related to demographics and consumer demand), the site selection process begins. During site selection, the Hospital's objective is to identify a site that will support the delivery of patient services needed in the community. The Hospital might engage a consultant or work directly with the Developer to establish and prioritize key criteria to help guide the search for potential sites. Examples of common criteria include size (acreage), availability (on or off market), visibility, accessibility, topography, and configuration to name a few. Additionally, the Hospital might consider the pros and cons of a particular site's proximity to competitive services. Once all sites have been identified, the Hospital and Developer (or consultant) compare the sites based on the defined criteria, utilizing a weighted-average scoring methodology, to narrow the list to one specific site.

Once the site has been selected, the Developer, on behalf of the Hospital, will negotiate an inspection period into the purchase and sale agreement (the "PSA") for the site that provides enough time for robust due diligence that should include, among other things, land use and zoning evaluations, an environmental assessment, a title study and ALTA survey, a geotechnical assessment, preliminary civil schematic planning, a traffic analysis, a vibration analysis, and an electromagnetic frequency evaluation. This due diligence period should allow the Developer to terminate the PSA in the event any inspections or findings during the due diligence period reveal that the site will not support the planned development. Although the Hospital will likely invest a substantial amount of capital during its assessment of the site, effective due diligence helps protect against the undesirable outcome of the Hospital owning a property that is inadequate for its needs.

At this stage, because more work still needs to be accomplished before the Hospital is willing to commit to the project, the Developer is usually going to look to protect its time, energy, and capital by requiring some form of predevelopment agreement with the Hospital providing reimbursement of a negotiated amount of the Developer's capital outlay and services. This agreement protects the Developer from overcommitting resources for a project that never materializes. Market factors and the Hospital's track record on other projects and demonstrated commitment to the current project should all factor

into how flexible the Developer is when negotiating the predevelopment agreement.

Lastly, although the physicians will be critical for the long-term success of the project, the Hospital is typically the driver in the site selection process, working hand-in-hand with the Developer.

2. Entitlements

Site entitlement is the legal process the Developer will undertake to gain the necessary approvals for a real estate development plan. This process starts concurrently with the site selection process. Key aspects of the entitlement process will include obtaining changes in zoning or zoning variances, determining allowed density, identifying allowable uses, ensuring necessary access to public roads, identifying allowable parking ratios, and acquiring any other necessary permits. The Developer can save both time and money at this stage of the process by excluding potential sites that would not be approved for the Hospital's development plan.

The entitlement process does not end at site selection; final approval of the development plan will come in the form of a site plan permit and building permit, which requires the completion of the next stage in the process: planning and design. The Hospital and Developer will most likely be aligned at this stage of development in their shared objective of obtaining development plan approval. Certain aspects (e.g., parking ratios) may be of more importance to the Hospital if those aspects impact the overall use of the site and affect patient experience. These issues, however, will also be important to the Developer because they are important for the long-term satisfaction of the Hospital's stakeholders.

3. Planning and Design

The project starts to take conceptual form in the planning and design phase. With ever-changing needs in healthcare, long-term flexibility will be critical to the success of the development for all stakeholders.

Generally, healthcare providers often have different design philosophies. Some believe in designing from the inside out—programming for certain planned uses will drive the sizing and configuration of the facility layout. Others believe in designing from the outside in, allowing site conditions to influence or drive the size and configuration of the building before determining the interior uses.

Developers may also take different approaches to design based on the characteristics of a particular site. As outpatient services shift more and more to a convenience model, developers are increasingly programming medical services into larger, mixed-use developments. For example, when developing an urgent care center, a developer would design the project based on the services that will be provided, anticipating the standard needs for the services (parking, size, basic configuration, etc.) and then marketing the space to a variety of local, regional, and national providers. In contrast to the predictability of end-uses for urgent care center development projects, the project development needs for particular specialty groups are often unique, making it difficult for a developer to "pre-plan" for specific program needs. Typically, developers will want to design a building that allows for adaptability as provider and market needs change. One of

the Developer's goals here will be to minimize the risk of the facility reaching functional obsolescence in order to protect its exit strategy.

For this project, a group of employed primary care physicians and multiple third-party medical and surgical specialty physicians (the "Physicians") and the Hospital will collectively approach designing the project with specific healthcare services in mind. More specialized services will require more specialized design, which will subsequently impact lease terms (as discussed further in the Leasing section). The Hospital and the Physicians, however, may have dissimilar viewpoints regarding certain aspects of the design. The two stakeholders may, for example, have competing preferences surrounding branding and signage. Either stakeholder may already have a unique architectural brand implemented at other facilities in the market. The Hospital may require a higher level of building systems and materials to provide certain services in a hospital-based setting for reimbursement purposes. Or the Hospital's needs might impact site design to accommodate physical plant needs, generators, or similar items. Another common misalignment between the Hospital and the Physicians may relate to which services should be offered on the ground floor versus higher floors. The Hospital may want the highest acuity services with the most expensive (and sometimes heaviest) equipment on the ground floor (e.g., imaging centers or ambulatory surgery centers) with direct egress for surgical discharges. The Physicians, on the other hand, may argue that their services generate the most foot-traffic, as may be the case with primary care, or that they require space on the ground floor for easy access by patients, as may be the case with orthopedics, rehab/therapy, or pulmonology. All these considerations must be weighed and evaluated as the building design starts to take shape, but the guiding principle should always be providing the best possible patient experience.

4. Ownership Structure

The Hospital and Developer will need to consider how to structure ownership during four distinct time periods:

1. Planning Phase;
2. Lease-Up Phase;
3. Construction Phase; and
4. Stabilized Phase.

Ownership participation may vary across each of these periods in the project timeline. The Hospital and Physicians may join together in a joint venture to create synergies from medical services in the building, but they do not necessarily need to be partners from day one.

One possible scenario is that the Developer and Hospital have agreed that the Developer will own and control the project during the development/planning phase, as is typical on these types of projects. Following that phase, the Developer can either enter into a joint venture with the Hospital and the Physicians during construction or wait until the project is completed. Another consideration for the Developer is whether it wants to maintain a long-term interest in the project or sell its interest at some point after stabilization, either to the Hospital and Physicians or to an investor.

When it comes to ownership vehicles, limited liability companies (LLCs) and limited partnerships (LPs) are the two legal entity structures most commonly used in these types of projects. A significant issue to agree upon at this stage involves which stakeholder will hold the majority ownership interest in the LLC or LP. Regardless of which structure the stakeholders choose and which stakeholder holds the majority ownership interest, it is important to understand, and agree upon, who serves as the managing member in the LLC or who serves as the managing general partner for the LP.

5. Restrictions

As previously discussed, ground leases are a common real estate strategy deployed by hospitals for medical office building projects. Historically, and mainly for on-campus projects, ground leases have become more prevalent for off-campus projects and these facilities have grown larger and more complex with additional hospital-based services. Assuming the Hospital owns the land, the Developer will enter into a long-term (>50 years) ground lease. By carefully drafting certain control provisions into the ground lease, the Hospital can control the uses at the location and ensure the quality of services provided at the location are in alignment with its delivery of healthcare to the community. The long-term nature of the ground lease allows the Developer to source financing for both a construction loan and permanent financing. As described below, several control provisions that might be included in the ground lease create a natural tension, leading to the possibility of misalignment, between the Hospital and the Developer as well as between the Hospital and the Physicians. A few examples of these control provisions that the stakeholders might have different perspectives and objectives on include:

Permitted Uses and Use Restrictions

The Hospital will seek to control the uses in the building to ensure that they support its overall strategy of healthcare delivery to the community and avoid duplication of services. It will also be important for the Hospital to put in place controls that will maintain the quality of care at the location. Common examples of these restrictions include imaging services and certain types of procedures and therapy services.

The Developer should generally be supportive of the Hospital's efforts to control uses and maintain quality of care, but the Developer will also be focused on the leasing velocity of the building and efforts to reach stabilized occupancy (typically 95% occupancy) as quickly as possible in order to secure permanent financing. To accelerate leasing, the Developer may be incentivized to pursue tenants that are incompatible with the Hospital's strategy. Potential lenders will want to see a balance between the Hospital's desire to preserve the integrity of the building's occupants and the Developer's ability to quickly reach stabilized occupancy for the building.

Assignment of Third Party's Ownership Interest

The Hospital will want to control the Developer's ability to assign or sell its interests in the building to another party that is not proficient in owning and managing ambulatory medical office buildings. Depending on the Developer's motivations and ownership goals, it may

attempt to sell the asset soon after building occupancy has reached stabilization in hopes of creating an equity event for the investors. These competing interests create a situation ripe for misalignment of objectives between the Hospital and the Developer, or the new owner, especially if the new owner is not an experienced owner of medical real estate. Potential lenders will typically prefer the Developer to have liberal rights to sell, allowing the Developer to determine who to sell to and to sell for the highest price, which may not support the Hospital's overall strategy.

Ground Lessor's Right to Purchase and Rights of First Refusal

Given the substantial investment the Hospital is making, it may want a right to acquire the property in the future along with a right to first negotiate and a right of first refusal in the event the Developer elects to sell the asset. On the other hand, the Developer will want to give the Hospital as few rights as possible so that the Developer can pursue an exit strategy without being encumbered by any rights that the Hospital may have. This issue is typically heavily negotiated and can get detailed all the way down to specific valuation methodologies that must be utilized in future transaction events.

Minimum Thresholds

As is common in these types of projects, the Hospital may enter into a master lease with the Developer whereby the Hospital will lease a large percentage of the building and then potentially sublease other portions of the building to third-party Physicians. The master lease will outline the Hospital uses and third-party physician practices, and the Developer will typically be responsible for leasing the remaining portion of the building. The Hospital will want to commit to leasing only the space that is needed while the Developer and the lender will want the Hospital to commit to leasing as much space as possible.

6. Capital and Financing

All real estate development projects are funded by two forms of capital: equity and debt. The Developer will likely fund a portion of the required capital with its own equity or cash and will borrow the remaining capital as debt from a lender. As healthcare real estate has evolved and more sophisticated developers have entered the market, complicated capital structures have become the norm. Developers might maintain multiple capital partner relationships that look to invest in different parts of the capital stack, and each type of investment will carry different risks and possibility for return. In addition, capital investments might be for just the construction period with a defined payoff at completion or stabilization, or capital can be positioned to participate in the project for the long term.

Traditional "first position" debt is typically sourced from financial institutions, with local, regional, and national banks all active in healthcare real estate lending, as well as insurance companies and pension funds. The two most common types of debt are construction loans (these loans are shorter term in nature and designed to fund the construction and stabilization of the project before maturing) and permanent loans. A third hybrid product, referred to as a "construction/mini-perm" loan (these loans act like construction loans, but transition to act more like traditional permanent financing once the

project is completed), is also common. Mezzanine debt ("mez debt") is another common type of debt utilized in healthcare real estate developments. Mez debt has a higher risk profile than traditional debt because it takes a second position to the traditional debt in the event of a default by the borrower. It is common when there is a shortfall in total capital required after the traditional debt and equity raised for the project, and it is typically issued for a shorter time period. Mez debt is often paid off when the project is completed and/or stabilized and permanent financing has been put in place.

Certain types of equity investments can be for a defined or short period of time as well. The Developer may offer preferred equity investment options that provide "guaranteed" returns with lower risk profiles, versus common equity positions with higher risk/higher return opportunities. Alternatively, the Developer may offer common equity investment opportunities but provide different pricing structures depending on the status of the project at the time of investment. For example, equity pricing would be least expensive in the predevelopment phase; it becomes more expensive as key development milestones are achieved and risks are reduced.

The Hospital and the Physicians are typically going to be closely aligned on capital and financing objectives. The Hospital may consider funding healthcare real estate projects with equity through internally generated funds (i.e., cash), but with all the competing capital initiatives hospitals face, accessing debt financing can be an attractive option to fund new projects. Physicians, on the other hand, rarely look to fund new projects with cash. Although there are several types of private practice compensation models, generally these models share one thing in common: cash is flushed out of the organization on a regular basis to its physician shareholders. With minimal liquid working capital, physicians often look to debt financing to fund as much of the required project capital as possible. Physicians also typically prefer to avoid or minimize personal guarantees related to project debt. The two most common approaches to avoiding personal guarantees for physicians are (1) practice corporate guarantees or (2) shifting guarantees to the developer in exchange for certain fees and/or equity positions.

A Developer's financing objectives will vary more significantly depending on its size and capital resources. Many developers look to fund 5-15% of a project with their equity while seeking additional equity from physician and hospital stakeholders or by leveraging private equity or debt to meet remaining equity needs. Whether the Developer's strategy is to hold or sell will typically be the driving factor in how it structures debt for the project.

7. Leasing

At this point, the Hospital has probably identified service lines and specialties that it intends to offer the community based on a thorough market assessment. The Hospital may want to make sure the practices the Developer pursues will support the identified healthcare needs in the community. A balance between the Hospital and the Developer is needed to allow the Hospital to have input into determining which services will be leased in the building while allowing the Developer to achieve stable occupancy. Areas that can cause misalignment in the leasing process are:

Building Rental Rate

The Developer will seek an annual return on the building's project cost, known as the rent constant, based on a negotiated percentage return in the form of rent payment. In the Hypothetical, the project costs are \$45,000,000. If the Developer is looking for an annual return of 7.5%, the resulting annual rent, excluding operating expenses, will be \$3,375,000 or \$22.50 per square foot ($\$45,000,000 \times 7.5\%$). The rent constant is a heavily negotiated point that may also implicate regulatory compliance laws such as the Stark Law; if third-party Physicians are entering into leases in the building, the rent they pay must be consistent with fair market value. If the fair market value rate is not sufficient for the Developer to meet its desired annual returns, misalignment can occur.

Hospital Alignment with Tenants

The Hospital will want to maintain control over the types of occupants in the building so that the occupants support and/or add to the Hospital's services in the community. The Developer will likely support the Hospital's practice strategy but will also need to accelerate leasing of the building to find appropriate financing. This can lead to misalignment of objectives between the Hospital and Developer.

Sizing

Due to the scope of investment the Hospital will be making in the project and in the community, it will want a building that allows them to expand and grow operations over time. At this point, the Developer might conduct a feasibility study to determine market data such as supply and demand, occupancy of competitive buildings, uses, and rental rate growth. If the results of the study are inconsistent with the Hospital's desired scale, misalignment between the parties can occur. The Developer's lender will also be concerned with financing a project that is not consistent with current market demands. A balance will be necessary between the Hospital's long-term strategy and the Developer's ability to reach and maintain stabilized occupancy.

8. Operations

Once the medical office building is complete, it will be critical for the Developer to either provide management services or retain property management services from a third party to support the operations of the building, including patient experience and delivery of care. The Hospital may have direct oversight as to who is hired to provide property management services to protect the quality of management. All stakeholders are likely to be aligned at this point. Unique challenges presented by ambulatory medical office buildings require a property manager with substantial experience in managing not just commercial office buildings but specifically medical office buildings. A few areas of concern regarding property management are:

Standard of Care

The medical office building was developed with the ultimate goal of delivering quality healthcare to the community. Close management of patient experience from the time they arrive on the site through arrival at their physician's office is important to maintain a high standard of care. Baseline elements that help ensure a positive patient experience include branding, wayfinding, providing easy access for patient drop-off, sufficient and easily identifiable tenant listings, parking, seating areas for patients in building lobbies, clear signage in elevators, and patient-friendly key panels. More advanced expertise in medical office building operations will help to address the additional impact on mechanical, electrical, and plumbing systems, particularly when specialty services are provided (e.g., imaging, surgery centers, and radiation oncology). Concentrated management oversight will ensure effective and efficient clinical operations while preserving the building's value as an investment.

Communication

As previously mentioned, the Hospital may master lease a substantial portion of the building that will include both hospital services and hospital-physician suites. The Hospital will sometimes communicate operational issues that are relevant to the users of the master space that may also impact third-party occupants in the building. It is important for the property manager to understand the desires of the different clinical users and navigate the overlapping impact on all occupants of the building.

Conclusion

Developing any ambulatory real estate project will present various opportunities for misalignment between the health system, the physicians, and the developer. But common ground can be reached if each party works to understand the others' perspectives and long-term objectives for the project. With decades of experience in the healthcare real estate industry, RTG can help ensure alignment between key stakeholders, enabling successful healthcare ambulatory real estate development projects.

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The Art of Physician Consolidation

This is a collaborative piece written by SCALE Healthcare, formerly SCALE Physician Group, and our partners at Epstein Becker & Green.

Roy Bejarano, Co-Founder & CEO | SCALE Healthcare
roy@scale-healthcare.com

Gary Herschman, Health Care and Life Sciences Attorney | Epstein Becker & Green

Emma McGregor, Associate | SCALE Healthcare

Elizabeth Scoda, Intern | SCALE Healthcare

Now more than ever, individual physician practices face complex challenges and an unpredictable industry environment. One way to protect themselves from these challenges and the obstacles associated with evolving market dynamics is to grow.

Growth can be beneficial regardless of whether a group wants to remain independent, or partner with a hospital, private equity investor, or national healthcare company. Being part of a larger organization has many benefits that can enhance a group's ability to survive and thrive in the uncertain future, most significantly by having a professional, corporatized infrastructure—such as an advanced electronic medical record; finance department; managed care contracting; population health expertise; and billing/collection, human resources, and compliance functions, etc.—that can be shared by many, as well as greater access to capital for strategic positioning and weathering pandemics and economic downturns. Physician practices are thus faced with a difficult decision—how do we grow?

The following discussion focuses on why practice consolidations offer a broad range of benefits to stakeholders and can result in a more valuable or sellable platform in the future or increase the likelihood of success in remaining independent. SCALE, along with the expertise of our vast network of operating partners, has developed a playbook for executing a successful physician growth strategy and believes that practice consolidation is a significant opportunity for many existing physician practices looking to grow. This playbook can help consolidating practices tackle the unique complexities that come with combining business processes, while creating significant value in both the short and long term.

Why Is Growth Necessary?

Over the past five to ten years, the physician marketplace has transformed in a number of ways, including a significant decrease in private practice physicians and a correlated increase in those working in hospitals and large investor-minded companies. These large and growing health systems change the competitive dynamic for independent practices, who are now faced with the need to grow or develop a niche market in order to survive.

In addition to health system growth, the market push to value-based care puts pressure on practices to grow in order to spread financial risk and implement a successful value-based model. Smaller practices lack the operational ability or infrastructure to implement these models, while larger practices must grow to reach the scale required for effective value-based care. Similarly, the formation of Accountable Care Organizations has also driven physician practices to expand in order to offer coordinated care.

Lastly, medical practices are becoming more complex from both an organizational and an operational perspective. Practices need to invest significantly in technology, be ready and able to quickly adapt to new regulation, compete on pricing, and otherwise maintain and/or grow market share. *See Figure 1.*

Figure 1



Pressure to deliver higher-quality care and results conveniently and at a lower cost will continue. On top of preference changes for how healthcare services are delivered, expectations of patients, policymakers, and payors also are shifting. The fluctuating demands of provider care are diverse in nature and require time, expertise, and resources to navigate. These evolving dynamics and challenges require practice growth to overcome or to execute a successful and effective strategy to address them.

How Should Practices Grow?

“The question that must be answered is how to consolidate in ways that support independent physicians and improve patients’ access to cost-effective, high-quality care.”¹

Unlike many other industries, physician practices are unable to sacrifice any segment of operations to ensure consistent quality with growth. Patients expect quality in every aspect of care that is provided. Thus, maintaining or improving the quality of care is a key consideration for organizational growth.

Physician practices generally choose to maximize their value through organic growth, practice consolidation, or a timely mix between a private equity transaction and consolidation occurrence. However, we have found that the most effective pathway to create meaningful and significant value for many practices has been through the implementation of a practice consolidation strategy prior to initiating any private equity backing or other partnership with a large healthcare organization.

Standalone organic growth allows the physicians in charge to retain control and capture all of the upside benefits of growth. However, this method of growth tends to require a longer time to execute and has higher risk as all investment is supported by one entity.

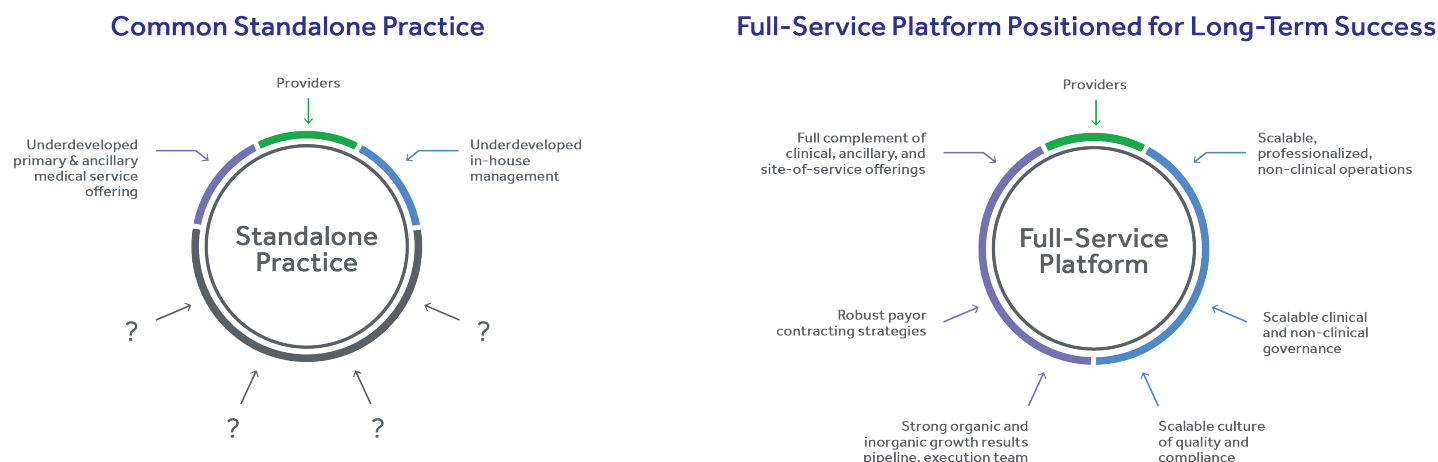
For example, practice mergers in advance of or simultaneous with a private equity deal can offer a catalyst for consolidation through the private equity partners. However, this process can reduce the list of potential longer-term viable buyers, create deal complexity, spread focus and priority across two projects—consolidation and a merger/acquisition—and thereby increase the potential for both forgone valuation upside and post-close execution risk. Practices that enter early private equity deals prior to scaling see a faster pathway to liquidity and delay merger integration complexity until after the deal closes. However, the upfront valuations are likely to be less as they reflect the practice’s limited scale and effort required to grow after the deal closes, and instead, the private equity firm captures most of the scaling upside.

Compared to the growth methods mentioned above, practice mergers prior to pursuing a private equity deal have the most benefits. *See Figure 2.*

Although there is always some merger and integration risk, consolidation provides a faster pathway to achieving scale relative to standalone growth, allows the practice owners to optimize their bottom line and strategic market position prior to selling, and offers future add-on targets the competitive differentiation of being an independent alternative. By focusing first on the planning and implementation of the merger itself, consolidated practices are equipped to reap the most benefits if they do decide to later pursue a private equity arrangement (or other partnership) in their next step of development. Practice consolidation is not a substitute to a sale transaction, but rather, it is a step toward building a more valuable and sellable platform.

Through consolidation, the new organization formed may have significant opportunities the standalone practice may not. These opportunities include economies of scale, market attention, shared investment, diversification, access to capital, and equity value.

Figure 2



Economies of scale is the ability to negotiate cheaper prices from suppliers by increasing the number of purchases. A larger practice is able to enjoy this purchasing power. Market attention refers to the combined practice's access to strategic partnerships, payor relationships, and referral relationships—all of which can help the newly combined group increase its value. Shared investment is all services that can now be shared across the larger group rather than the smaller group—management expenses, marketing, technology and infrastructure, recruitment, and innovation. In terms of diversification, an expanded group enhances the provider and referral network stratification by bringing new providers into the fold and improves provider succession planning alternatives. Having greater access to capital allows a growing group to achieve all of the foregoing characteristics of a professional and corporatized infrastructure. Lastly, the combined group has an increased equity value—they have the momentum by being the larger group and a more developed practice of reasonable scale tends to receive a more favorable valuation.

Deciding to Consolidate—Now What?

As highlighted above, while practices have many avenues to pursue growth, SCALE believes that the most effective pathway for many practices is through practice consolidation. But simply deciding to pursue consolidation as a growth strategy does not guarantee successful growth or long-term value. Practice consolidation is both an art and a science—there are many steps and formulas to follow as well as experience and knowledge the appropriate partner can bring to a particular situation. Each consolidation scenario is unique in certain respects, but there are a few key components to consider to be effective and create value through any transaction.

When it comes to consolidation, practices should “begin with the end in mind” (as coined by Stephen Covey). This includes picking the right practice(s) to consolidate with and developing early in the process the new combined group's strategy. The team needs to know what their goal is before entering into any transaction. Throughout the life of the consolidation, the following three questions should be considered:

1. What are we building?
2. Why are we building it?
3. How are we building it?

What are we building?

First, look at the current state of the practice. What are its core capabilities? What is the practice's position in the market? Next, think through the end goal of the consolidation—what is the ideal future state of the combined practice? Most likely, this target state will include centralized non-clinical functions with a reduction in the overhead cost as a percentage of revenue. It will also most likely include a new standardized IT system across the entire practice.

This ideal future state should also include both operational improvements and expansion plans. The goal of consolidation should not be to simply increase the number of physicians or patients seen. Instead, a practice considering consolidation should take the opportunity to review all operational processes and determine what makes the most sense moving forward. This review process can also help in choosing a target practice for consolidation. Identify areas where the practice may not excel and find a target that is stronger in those areas. Again, the key question is: What do you want the practice to become in an ideal world? Thinking through this question can help determine the priorities when pursuing a consolidation.

Figure 3



As noted above, one of the opportunities of consolidation is for a practice to optimize its strategic position prior to a private equity sale or other strategic partnership. Therefore, it is important to think about what that strategic position should be, including the combined practice’s growth targets. Is the practice trying to grow through adding patients in one clinical area? Is expanding clinical services or adding ancillary services the target for growth? There is no right answer when it comes to determining a strategy or goal for the combined practice, but there needs to be an answer.

In addition to high-level strategy and goals, once a target is identified and the deal is finalized, a clear organizational structure needs to be developed. This organizational structure usually involves creating a Management Services Organization (MSO) umbrella over all practices. One example of an MSO is shown in Figure 3.

Within this organization, think through which functions will be outsourced to a third party and which will remain in-house. The organization’s structure should always reflect the strategic and expansion objectives.

Why are we building it?

The “why” for consolidation was most likely discussed before entering into any agreement or consolidation planning. However, it is important to think through this question. Why is consolidation the best growth opportunity for the practice as opposed to the other options?

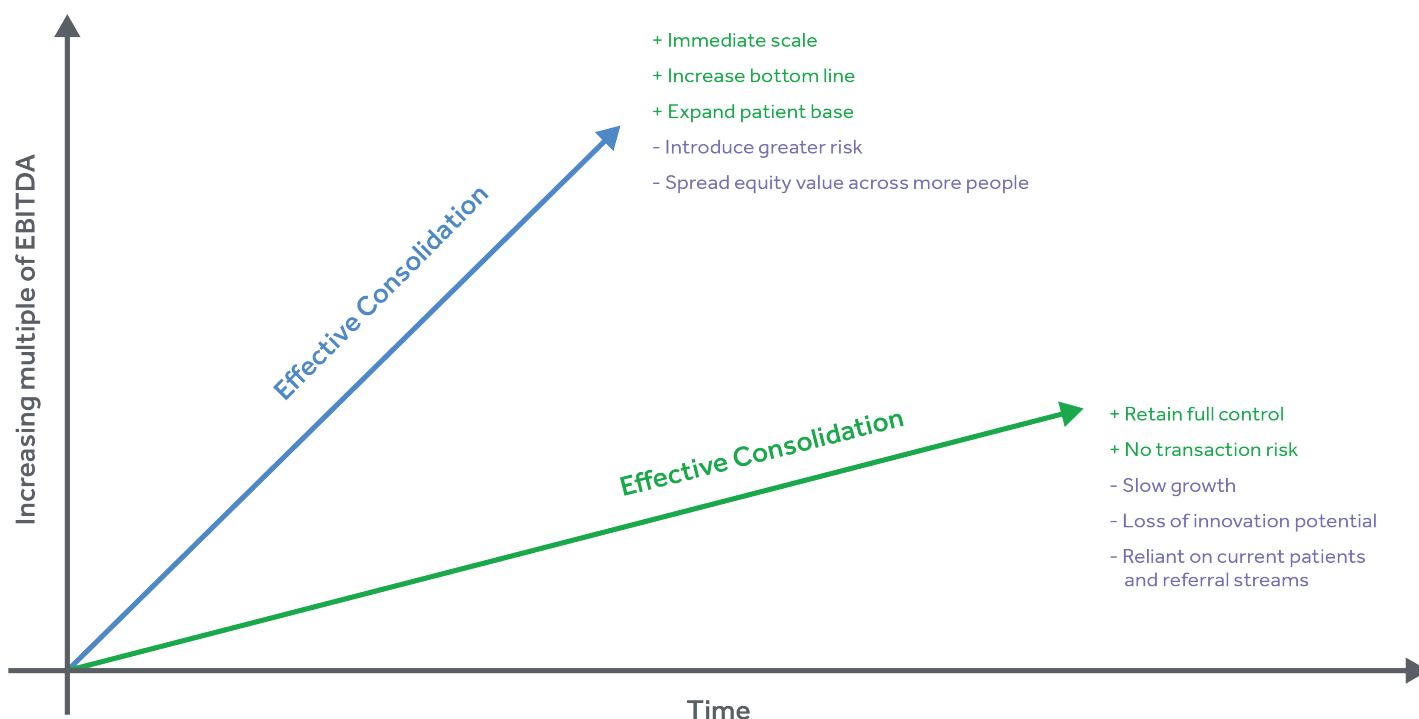
As previously noted, consolidation makes sense for many groups, but ultimately depends on a number of factors, including size, specialty, and market position.

Practice owners should consider what opportunities consolidation will provide and why those opportunities are crucial to practice growth—both from an offensive and defensive position. Offensively, will consolidation provide the practice an increase in shared capital for innovation investment or platform development? Will this growth put the practice in a better position to negotiate with payors, hospitals, or other vendors? Defensively, will this consolidation improve the practice’s market position by capturing more share or a different segment? Will the consolidation enable the practice to pool investment in operational systems to decrease the financial burden of these overhead shared services?

Lastly, think long term. How will this consolidation change the wpractice’s equity value over the next five years? *See* Figure 4.

Will this transaction strengthen the practice’s position in future transactions—whether they are with a private equity group or another consolidation? Within the market, a particular platform’s ability to command a premium valuation will be driven largely by how developed the platform is and how well the platform can execute standalone growth and development. Will this consolidation help the practice work towards commanding a premium valuation?

Figure 4



How are we building it?

Once the “what” and “why” have been addressed, the practice leaders, and most likely a consolidation execution partner, need to develop the roadmap of “how” to integrate and execute the transaction effectively. Developing a strategic roadmap is key—you won’t get to where you’re going unless you know how to get there.

This roadmap will most likely include multiple phases—the entire integration will not happen all at once—and operational workstreams. Breaking down each phase into a handful of objectives based on a timeline helps a team stay on track and understand what the priorities are. Within each non-clinical area, the team should mock-up what it would look like to have minimal integration and full integration to decide which scenario makes the most sense for initial rollout. Similarly, it is important to delegate responsibility effectively—whether to internal stakeholders or a third-party partner engaged to assist in executing the consolidation.

From a legal perspective, some important issues that all parties should agree to in advance of any practice consolidation include:

- Are acquisitions and mergers achieved via payment of a purchase price to smaller groups, or allocation of ownership percentage in the surviving, larger practice entity—and what methodology is used to achieve the respective valuations?
- What physician compensation methodology will be employed moving forward, and to what extent will there be overhead allocations?

- How will profits be allocated from different regions and ancillary services?
- How will the post-consolidation governance of the organization be structured, vis-à-vis both a Board and regional/division determinations, what if any major decisions require a vote of equity owners, and what percentage votes are required for actions at the Board and owner levels?
- What, if any, terms of a future investor/partnership transaction are agreed upon in advance?

There are many levels of third-party support that a practice may need, which could range from an advisory role to fully outsourced solutions across one or many workstreams. Support could also be clinically focused or more operational. Practice leaders should determine what level of support makes the most sense to execute a successful consolidation.

Consider building out a summary roadmap, like the example in Figure 5 involving a client consolidating eight urology practices, and use it to guide the team throughout each phase. Consolidations can be complex, but the more preparation upfront, the smoother the process will unfold.

Throughout the execution of the consolidation, check back to the “what” and “why” outlined at the beginning of the process. Is the practice still on track to build what it wanted to achieve? Are the goals and growth targets being realized as envisioned?

Figure 5

	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Engagement, preliminary diligence and kickoff	Completed									
Legal										
Agree and signoff on Entities and Structures										
Draft MSO, Care Center, Withdrawal, PLLC and other Docs										
Execute legal documents				Ready						
RCM										
Committee decision on EHR / PM										
Develop billing solution and structure										
EHR / PM Implementation										
Billing Team Implementation:										
Credentialing										
Go live with initial plans, and continue transitioning plan billing to single TFN							Ready			
Finance										
Discuss and signoff on finance solution and preform diligence										
Develop chart of accounts, policies, adopt software										
Vendor lists, import of historical financial data										
Integration and conversion of systems across all practices over 60 days						Ready				
EMR										
Diligence and confirm Urochart (or other eCW)										
Buildout application, dictionary and other functions of EMR										
Develop and test all relevant interface (lab, PM, software, etc.)										
First clinical and appointment go-live										
Eight practice platform integration							Ready			
HR										
Confirm common payroll platform										
Payroll integration					Ready					
Payor Contracting										
Begin credentialing										
Complete IPA credentialing					Ready					
Begin independent contracting strategy										

There is no “one-size-fits-all” model to consolidation, but the discussion above can be a tool to help frame the consolidation as a whole—from idea to execution. SCALE believes physician practice consolidation is a way to create immense value for both practice owners and patients. Thoughtful planning and execution of a consolidation can create significant growth, increase the ability to innovate, and provide a better experience for patients.

Endnotes

¹ Praveen Suthrum, *Physician practice consolidations: It's only just begun*, STAT, Feb. 27, 2020, <https://www.statnews.com/2020/02/27/physician-practice-consolidation-its-only-just-begun/>.

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