

Physician Alignment: Tips & Trends

2023 Biannual Report

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Physician Alignment: Tips & Trends

2023 Biannual Report

The past two years have reflected many of the same healthcare trends we outlined in VMG Health's 2021 PATT Report, such as telehealth expansion, value-based care initiatives, and the continued growth of private equity participants. Financial pressures and staffing issues have been exacerbated these past two years, causing healthcare leaders to examine innovative ways to improve their bottom line.

The healthcare landscape continues to be complex and highly regulated with physicians being at the center of nearly every strategy. A physician's impact on financial operations, patient care, and an organization's culture make physician alignment critical for any healthcare organization to succeed. To help leaders understand the best options for alignment strategies, the 2023 PATT report provides timely insight into the latest trends and regulatory changes that impact physician alignment.

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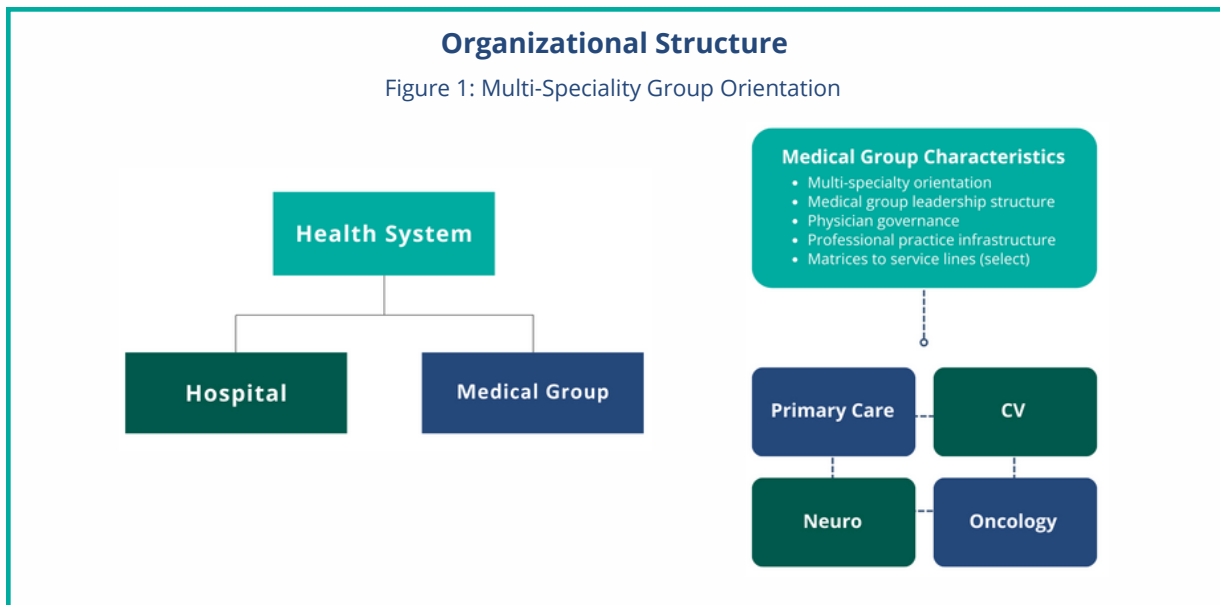
Health System Challenges & Strategies

As health systems continue to experience financial pressure, physician alignment strategies are a priority for potential growth opportunities. As a result of working on thousands of healthcare engagements each year, VMG Health has insight related to how health systems can strategically affiliate with physicians. Critical areas include understanding service line strategies and regulatory changes impacting reimbursement.

Migrating from Multi-Specialty to Single-Specialty Strategy

Whether to focus your efforts on a multi-specialty or single-specialty strategy is a critical question for healthcare leaders tasked with developing decisions around physician planning. Financial projections, recruiting efforts, and compensation models are just a few of the important factors that will be impacted based on the selected strategy. There are advantages and disadvantages to both, and the preference can vary based on circumstances and market dynamics. With that said VMG Health has recently observed a shift toward the single specialty strategy.

Obviously, health systems have invested in the development of employed medical groups for decades and the most recent wave began in the early to mid-2000s. The multi-specialty practice approach offers comprehensive care, convenience, and financial benefits such as the sharing of administrative staff and the potential for better contracts. Therefore, many of these investments have included some form of governance and/or management oversight related to developing policies and procedures, as well as streamlining operations, towards building a multidisciplinary culture. As a result, we have seen many health systems create a multi-specialty orientation to group design with primary care providers and specialty care providers operating under a single umbrella.

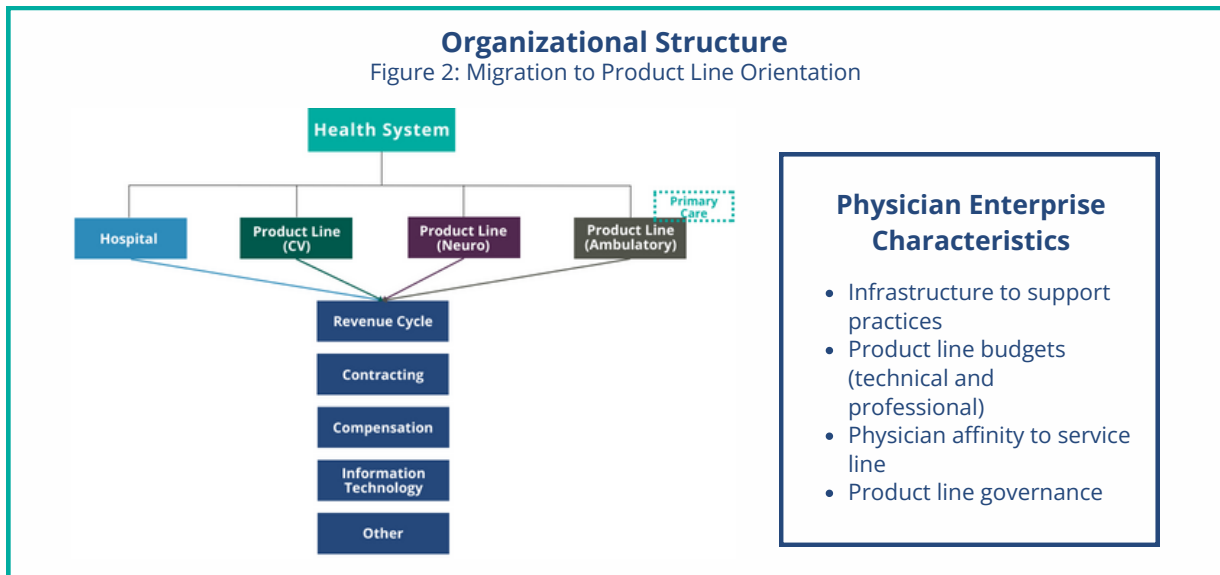


For a variety of reasons, multi-specialty orientation for employed medical group design has not lived up to its expectations. For many integrated delivery systems, multi-specialty compensation models do not portend substantive economic alignment among the “collective” of specialties, and in turn the terms of the individual employment

agreement trump everyone else. In contrast, independent, multi-specialty group practices have aligned economic interests so that a common “bottom line” is shared among the various primary care and specialty care disciplines. That alignment is largely lost inside of an integrated group practice where physicians are largely compensated based on productivity or invested time. All these opposing factors can make compensation models in a multi-specialty setting confusing and often misaligned. Since a successful compensation model is one of the critical areas for physician alignment, VMG Health believes this is a key reason for the shift to single-specialty strategy.

Other benefits of the single specialty strategy include developing expertise, streamlining workflows, branding, and addressing **market demand**.

Further, many physicians have a greater affinity for their respective service line (e.g., cardiovascular, orthopedic surgery, neurosciences, oncology, etc.) versus a multi-specialty group practice. Other benefits of the single specialty strategy include developing expertise, streamlining workflows, branding, and addressing market demand. As such, organizations are pursuing structural changes to employed medical groups. Increasingly, organizations are attempting to prioritize underlying product line orientation to drive better strategic and operational alignment. As shown in the exhibit below, this orientation is changing budgeting and management accountability. However, most systems recognize the inherent value of having infrastructure and developing scalable support (revenue cycle, contract administration, compensation administration, financial reporting, etc.) that promotes best-in-class offerings which can still be done with a single-specialty approach.



In addition to budgeting, shifting to a single-specialty strategy should consider the local healthcare market, patient demand, physician preferences, and the organization's business goals. Some physicians may choose to join existing multi-specialty groups to broaden their service offerings and take advantage of shared resources. However, others may opt for single-specialty practices to focus on their area of passion and expertise. Regardless of the selected growth strategy, healthcare leaders should be able to communicate how their positioning will benefit their physicians.

Understanding the Current State of Telehealth

Understanding telehealth as a resource and all its advantages is an important part of any healthcare leader's strategy. Not only does it impact reimbursement by providing a new revenue opportunity, but it also provides numerous benefits to providers including:

1. Improved work-life balance through increased flexibility and convenience.
2. Broader patient base through expanded reach and accessibility.
3. Better care for patients with easier follow-ups and patient engagement.
4. Coordinated care through easier communication between physicians and access to more patient data.
5. Reduced exposure to infectious diseases.

As a result of these benefits, telehealth has become a physician alignment tool for many health systems.

In short, telehealth has become an incredible way to increase access to healthcare while mitigating the challenges of limited resources for physicians and healthcare providers. Although telehealth has steadily grown over the past two decades, the challenges presented by the COVID-19 pandemic supercharged this growth. In fact, telehealth claims volumes increased 38x year over year, from February 2020 to February 2021. There were several significant changes that prompted this growth, and many of these changes were a result of the CARES Act.

First, Medicare changed its reimbursement for telehealth visits to be the same as in-office visits. Additionally, physicians were given the ability to reduce, or even fully waive, the Medicare patient cost-sharing for telehealth services. This made telehealth more attractive to patients. The CARES Act also removed location barriers and made it possible for providers to see patients who were in different states. The CARES Act also allowed healthcare providers to offer more types of visits such as emergency department visits, remote patient monitoring visits, and check-in visits. Additionally, occupational therapists and licensed clinical social workers were given the option to use telehealth to treat patients. Finally, technology HIPAA requirements were relaxed, and many more two-way audio-visual means like FaceTime, Skype, and Zoom, as well as audio-only telephonic services, were allowed for telehealth visits. This greatly increased providers' ability to offer this service to their patients. All of these changes were transformative to the way telehealth is viewed today.

Current Legislations Impacting the Future of Telehealth

From Washington to Virginia, states across the country are introducing legislation to expand telehealth beyond the CARES Act. Despite different geographical locations and political leanings, states seem to agree on telehealth's ability to increase access to healthcare. At the national level, two active bills, HR 4040 and HR 1110, both contain pro-telehealth legislation.

HR 4040 was passed by the House in July 2022 and is aimed at extending certain Medicare telehealth flexibilities beyond the end of the COVID-19 public health emergency (PHE). Specifically, until December 31, 2024, or the end of the PHE, whichever comes later, HR 4040 would allow Medicare beneficiaries to continue to receive telehealth services in any location they wish. In addition, this legislation would allow other healthcare providers granted freedom to practice telehealth via the CARES Act. This would include providers such as occupational therapists and physical therapists who would continue to provide telehealth services to patients. Finally, alongside evaluation/management services, it would allow behavioral health services to still be provided via audio-only technology. Within the industry, this bill has seen support specifically from the American Telemedicine Association and the American Counseling Association.

HR 4040 would allow **Medicare beneficiaries** to continue to receive telehealth services in any location they wish.

In addition, HR 1110 is an initiative that was commissioned by Congress with the explicit purpose of expanding access to telehealth services to Medicare and Medicaid beneficiaries. Under this piece of legislation, Congress would require two reports be provided, one by the U.S. Department of Health and Human Services, and the second by the Medicaid and CHIP Payment and Access Commission (MACPAC) and the Medicare Payment Advisory Commission (MedPAC). These reports would include a comprehensive list of telehealth services and the types of providers that could supply these services. Also, they would include a quantitative and qualitative analysis of the use of telehealth services, and would specifically focus on data regarding use by rural, minority, elderly, and low-income populations. Another part of the reporting would cover an assessment of the improvements or barriers in accessing telehealth services and an overview of the risk of fraudulent activity that could happen due to expanding telehealth services. Ultimately, these reports would be vital in shaping future policies around telehealth to help increase access to it and to improve the effectiveness of it.

For a more robust overview of historical and future legislation around telehealth, please see VMG Health's article, "[The Evolution of Telemedicine & What's Next.](#)"

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The last few years have seen major changes in how healthcare is delivered and [telehealth strategy](#) is critical for healthcare leaders to understand. The U.S. was able to tap into the large potential telehealth has to offer during the worst stages of the pandemic. As we move into the future, it will be important for state and federal governments to continue to improve regulations impacting telehealth to further expand access. That said, telehealth also comes with its challenges including privacy issues, technological barriers, and reimbursement policies. However, with continuous advancements and the integration of telehealth into healthcare systems, these challenges are being addressed to improve the overall experience for physicians and patients. From a physician alignment perspective, implementing telehealth in more areas of the healthcare continuum is a strategy that could alleviate some of the burdens physicians face and provide a more attractive work-life balance.

CMS Proposed 2024 Medicare Physician Fee Schedule Changes

On July 13, 2023, CMS issued the proposed rule for the 2024 Medicare Physician Fee Schedule (MPFS). Notable highlights address behavioral health access, telehealth flexibility, quality programs, and a new add-on payment code. Of course, the conversion factor (CF) changes are always an area of focus and continue to be proposed at a decrease, but the exact change will likely be confirmed in November. The Proposed Rule is open for a 60-day comment period that will close on September 11, 2023. Then, it is expected the Final Rule will be issued in early November 2023.

As mandated by law, the physician CF will be reduced from \$33.8872 to \$32.7476, and the anesthesia CF will be reduced from \$21.1249 to \$20.437. Historically, adjustments are made to this mandate before the Final Rule. Outside of the monumental 2021 MPFS final ruling, changes to the 2023 MPFS and the proposed 2024 MPFS track with historical year-to-year updates. However, certain specialties and areas of practice are projected to be impacted to a

higher degree due to coding updates and the continuing initiative of placing emphasis on primary care. A notable fee schedule comment was CMS proposing an additional delay to the implementation of the “substantive portion” for split/shared E&M visits to give organizations time to prepare. The proposed rule would move from a medical decision-making approach to a time-based definition of how these codes can be billed. If implemented in 2025, this new guidance would result in a non-physician practitioner only receiving 85% of the physician fee schedule rate if they performed at least half of an evaluation and management visit.

While the proposed overall payment rate (-1.25%) and conversion factor decrease (-3.34%) will impact all providers and organizations, non-primary care providers and organizations stand to face a greater loss than their counterparts. This is partly due to the proposed implementation of healthcare common procedure coding system (HCPCS) code G2211, an add-on code for complex office and outpatient E&M visits. Specifically, CMS notes that approximately 90% of the negative budget neutrality adjustment to the conversion factor for CY 2024 is attributable to G2211 with all other proposed valuation changes making up the other 10%. Based on an analysis of the proposed changes to all specialties, VMG Health has calculated interventional radiology and radiology to experience two of the biggest decreases at 4% and 3%, respectively. Not surprisingly, family practice and psychiatry are highlighted with increases at 3% and 2%, respectively.

As it relates to behavioral health, CMS proposed several new provisions to expand access. If implemented, these provisions would create some of the most significant changes to promote access to behavioral health in the history of the Medicare program. One major change includes allowing the Health Behavior Assessment and Intervention services to be billed by clinical social workers, marriage and family therapists, and mental health counselors (MHCs). In addition, the proposal would allow MHCs to provide integrated behavioral health care as a part of primary care settings. Lastly, CMS proposed an increase to the work relative value units (RVUs) for psychotherapy codes over a four-year transition period.

Telehealth was also a big theme, and this is likely due to its recent rise in adoption and cost-saving benefits. On track with the behavioral health initiatives, the proposal included adding newly recognized telehealth practitioners who are focused on behavioral health. Other proposals included the addition of newly covered procedures and the creation of differential payment based on the place of service.

For the Quality Payment Program, **200 quality measures have been proposed for 2024** and reflect changes, deletions, and additions to the 2023 quality measures.

Lastly, for over a decade CMS has largely focused on the initiative of higher quality, lower cost care. As a result, there continue to be updates to the federally funded programs each year. For the Quality Payment Program, 200 quality measures have been proposed for 2024 and reflect changes, deletions, and additions to the 2023 quality measures. In addition, CMS proposes five new, optional Merit-Based Incentive Payment System (MIPS) Value Pathways which include:

1. Focusing on Women’s Health
2. Quality Care for the Treatment of Ear, Nose, and Throat Disorders
3. Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV
4. Quality Care in Mental Health and Substance Use Disorders
5. Rehabilitative Support for Musculoskeletal Care

Also, it is worth noting there is a new proposed track to the Shared Savings Program that offers a higher level of risk and reward. Based on CMS' continued focus on value-based care, quality, and cost savings initiatives should continue to be an area of opportunity for healthcare leaders to align with physicians.

It is important for healthcare organizations and providers to understand the MPFS changes and to establish a managed care strategy. Preparing for changes in reimbursement related to primary care, behavioral health access, telehealth expansion, and quality initiatives can have a real impact on financial success. One prominent area that is evolving due to fee schedule changes is physicians who are helping healthcare organizations achieve high-quality outcomes. There are currently numerous alignment strategies to assist with these initiatives and VMG Health has the latest insight on strategy, coding, and valuation guidance associated with value-based care initiatives. We have helped clients develop effective compensation plans aimed around value-based care and have provided valuation opinions for all types of arrangements including quality bonuses, co-management programs, shared savings agreements, and clinically integrated networks/ACOs. Finally, VMG Health's Coding, Compliance, and Operational Excellence Division understands the coding nuances in all areas of the MPFS which is critical to maximize reimbursement and maintain compliance.

Handling the Coverage Agreement Surge Due to the No Surprises Act

The No Surprises Act was a landmark piece of legislation aimed at protecting patients from unexpected medical bills. Although the law is a significant step forward for patient protection, it has resulted in challenges for healthcare providers including the need for additional financial support from facilities through coverage arrangements. VMG Health has seen an increase in these arrangements at hospital service lines, particularly for the specialties of radiology, anesthesia, and emergency medicine. In addition, there has been a surge in anesthesia coverage agreements in the ambulatory surgery center setting.

For an in-depth analysis of this, please see, "[The No Surprises Act Causes Growth in Anesthesia Coverage Payments at ASCs: What You Need to Know.](#)"

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Prior to the No Surprises Act, patients who unintentionally received care from an out-of-network provider could potentially have received a "surprise medical bill" from a facility or provider. This occurred in emergency room situations where the patient did not have the ability to select the emergency room, physicians, or ambulance provider. Additionally, surprise bills resulted from services provided for a patient by an out-of-network provider at an in-network facility. This was common for services provided by anesthesia, first assist, and radiology providers.

Additionally, healthcare costs and pricing information were often difficult to obtain prior to receiving treatment, and billing disputes between healthcare providers and insurance companies often left patients caught in the middle.

Due to these circumstances, the No Surprises Act was passed as part of the Consolidated Appropriations Act, 2021 and took effect on January 1, 2022. Now after the patient receives care, the healthcare provider will verify the patient's insurance and determine if they are in-network or out-of-network. If the patient receives care from an out-of-network provider at an in-network facility, the patient is only responsible for their in-network cost-sharing amount, such as deductibles, copays, or coinsurance. Then, the provider will bill the insurance for their services. After the insurance company processes the provider's claim, the patient will then be billed for their responsibility for the in-

network cost-sharing amounts. If there is a dispute between the provider and the insurance company regarding reimbursement for out-of-network services, the provider and insurance company may engage in the Independent Dispute Resolution (IDR) process. This process involves an independent arbiter who reviews the case and determines the appropriate payment. Unfortunately, the industry has seen numerous providers and payers enter negotiations, and many providers have seen a significant decrease in reimbursement.

When entering a **coverage arrangement**, an analysis should be completed related to staffing requirements and the resulting compensation must be **fair market value**.

As a result of shortfalls in reimbursement, providers with hospital service line agreements and ambulatory surgery center coverage arrangements may be requesting additional compensation from facilities. When entering a coverage arrangement, an analysis should be completed related to staffing requirements and the resulting compensation must be fair market value. There are several important factors for facilities to consider when conducting this analysis.

1.) Coverage Requirements: Consider the hours dedicated to the agreement to determine required provider FTEs. This calculation may include on-site time, off-site/on-call time, medical directorship, and other administrative services. Trauma designations or other certifications held by a facility member may necessitate certain minimums, so it is vital to keep these in mind while working with a group.

2.) Provider Expertise Requirements: Since provider compensation is typically the largest expense driver in coverage arrangements, it is important to ensure the right level of expertise is provided. However, the ability to lower provider expenses by leaning on APPs and other physician extenders should be considered.

3.) Quality Incentives: If compensation is being tied to quality, facilities should focus on outcomes-based metrics that the providers will have the ability to demonstrate their impact on. The tracking of outcomes is important and financially incentivized targets should require the attainment of higher quality versus maintenance of current outcome achievements.

4.) Overhead: Provider groups typically will need to incur some additional costs beyond provider compensation expenses, including billing and collection expenses and general office support expenses.

The No Surprises Act is a major step towards protecting patients from unexpected medical bills, but it presents significant challenges for healthcare providers. Providers must adapt to the new law's requirements, which can be time-consuming, costly, and complicated. While providers will need to be proactive in addressing these challenges, facilities may be asked to provide further financial assistance in certain arrangements. Having open and thorough conversations about the needs of the facility and balancing the challenges faced by providers groups will be an effective way for facilities and providers to continue partnering to provide high quality care for patients.

Key Takeaways

To identify successful opportunities for physician alignment, understanding trends in service line strategy and considering regulatory guided reimbursement changes are critical. As we move into 2024, VMG Health believes the focus on single-specialty, adoption of telehealth, and the initiatives around behavioral health and value-based care will be game-changing strategies.

Private Equity & Physician Strategy

With the surge of private equity companies entering the healthcare industry, it is important to understand the new opportunities physicians have for these market participants. PE's unique strategy has proven to be attractive to physicians and can be a catalyst to provide more innovative alignment models for other healthcare organizations to consider.

Understanding Private Equity's Involvement in the Physician Practice Setting

Health systems, physician practices, and private equity companies new to healthcare are all curious about the PE strategy that has swept up many medical groups. Comprehending the PE play is important when considering your organization's physician alignment strategy. The basics behind Management Service Organizations (MSOs) and Management Service Agreements (MSAs) should be fully understood to create a clear picture of physician alignment opportunities in today's market.

As physicians explore different opportunities regarding employment and strategic partnerships, VMG Health has seen an increase in PE activity in the physician practice setting. Specifically, PE investments in healthcare have climbed from approximately \$20 billion in 2015 to \$75 billion in 2022 with deal volume surpassing 1,000 in each of the last three years. However, PE's involvement with physician practices is not as straightforward as other industries. Due to healthcare's regulatory landscape, including Fee Splitting Prohibition and the Corporate Practice of Medicine (CPOM) Doctrine, unaccepted lay people are restricted from owning any portion of a practice. This rule is set in place to not only protect patients but also protect clinical decision-making. With that said, PE transactions typically include the creation of an MSA which involves an MSO that contracts with a friendly physician practice to provide all non-clinical aspects of a practice's operations. The resulting management fee serves as a return on investment for PE and should be set at fair market value (FMV).

With a highly fragmented provider mix, the physician practice market is an attractive market for PE. PE typically seeks to establish a large physician group as a platform business and then deploys additional capital at lower-than-platform multiples to add additional physicians and/or practices via bolt-on acquisitions. This strategy creates automatic multiple arbitrage as the entire portfolio sells at a higher platform level multiple. Additionally, the PE strategy seeks to create value by establishing ancillary service lines (i.e., ambulatory surgery centers, laboratories, etc.). This adds another stream of earnings that can be extremely valuable during a transaction.

For physicians, **the PE model provides numerous benefits** such as physicians receiving a lump sum amount upfront which carries a multiple on the practice's earnings.

Additionally, key physicians receive “roll-over” equity in the MSO that provide future opportunities to “bite at the apple” and serves to keep physicians motivated to maintain and grow the platform. Having a connection to an MSO that assumes all the administrative burdens associated with running a practice is also a key benefit. This gives physicians the ability to focus more on their patients and other clinical aspects of the business. Lastly, physicians retain control and governance over the clinical operations of their practice.

For more details about MSOs and how PE invests in healthcare, go to VMG Health’s article titled, [“Physician Practice Strategy: The Private Equity Play.”](#)

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Diving into MSA Observations & Statistics

To really understand the opportunities PE firms provide for physicians, VMG Health has summarized important insights and key statistics from our work in this area. As mentioned previously, PE’s involvement with physician practices usually involves a “Friendly PC” model with an affiliated MSO and associated management fee. To better understand how these arrangements are structured, VMG Health analyzed over 120 MSAs. These were the big takeaways:

- **Targeted Specialties:** In 2015, PE appeared to focus on a handful of specialties such as anesthesia, dermatology, and gastroenterology. Now there is a variety of consolidated specialties consolidating being targeted by PE including ophthalmology, primary care, urgent care, cardiology, orthopedics, women’s health, behavioral health, and others. As PE success continues to grow, untapped specialties should be ripe for consolidation.
- **Observed States:** VMG Health’s experience with MSAs involving PE is limited to states that have adopted the CPOM doctrine. States like New York and New Jersey are known to have strict CPOM standards so it is no surprise these states are popular for PE involvement. While California and Texas may be more relaxed in their adoption of CPOM, the sheer geographic size and highly fragmented markets make them top targets for PE focus as well.
- **Varying Fee Structures:** VMG Health notes that the most common fee structures in MSAs are fixed fee, percentage of revenue, and markup to costs as these accounted for 48%, 31%, and 18% of observed arrangements, respectively. Recently, VMG Health has seen MSOs attempt to get more creative with fee structures as PE continues to innovate. It is important to be aware of state-specific requirements when entering an MSA and determining an appropriate fee structure.
- **MSA Term:** With platform multiples exceeding 10x for many transactions, it is not uncommon to see MSA terms that are more than 10 years. While the total MSA term may last for decades, it is also very common to see shorter renewal periods. Of the MSAs VMG Health has seen, nearly half of them included a term of 20 years or more. However, it is important to note the holding period for most investments is much shorter.

The most common fee structures in MSAs are **fixed fee, percentage of revenue, and markup to costs** as these accounted for **48%, 31%, and 18%** of observed arrangements, respectively.

For more information on the observations on the previous page, please see VMG Health's article titled, "[Key Findings from Private Equity's Healthcare Play: Management Services Agreements.](#)"

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Additionally, to better understand how the MSA arrangements work in the market, VMG Health experts have outlined some high-level observations from their valuation work associated with these arrangements. Common value drivers include:

- **Contracted Services:** Typically, the MSO will take on all the responsibility and expenses, except for clinical personnel expenses. With that said, only 11% of the observed MSAs had the professional entity retain material services that are normally viewed as the responsibility of the manager.
- **Priority of Payments:** Typically, the MSO will take on most of the arrangement's business risk by making the management fee subordinated to most other expenses, particularly the expenses of the professional entity. Therefore, only 10% of the observed MSAs did not have the MSO take on most of the business risk through a subordinated management fee.
- **Deficit Loan Funding:** Another demonstration of business risk is through a deficit loan funding covenant. Of the observed MSAs, approximately 47% had a deficit loan funding covenant present.

Only **10%** of the observed MSAs did not have the MSO take on most of the business risk through a subordinated management fee.

Physician Compensation Trends in PE-Backed Platforms

Private equity growth remains strong in the physician practice sector and the amount of dry capital on the sidelines will continue to be deployed across practices (orthopedics, cardiology, urology, primary care, dermatology, etc.). This will inevitably disrupt the traditional continuity-based care and ambulatory migration from hospitals. Despite the increase in activity, PE companies continue to see the age-old problem of aligning incentives through effective compensation models post-acquisition. To this end, compensation designs for a PE-backed platform or a tuck-in practice must be compliant with regulatory provisions and must maintain alignment with underlying attributes of the practice's revenue and expense structure.

While variation exists, the most traditional transaction sequence involves the creation of "synthetic EBITDA" through an income reduction that the practice is willing to take. As a result, the "synthetic EBITDA" becomes margin that is subject to valuation and helps generate cash to the physician owners and/or create rollover equity for the PE platform or practice MSO.

In the hypothetical example below, a practice generating "Run Rate" Earnings Before Physician Compensation (EPBC) of \$8M is illustrated to sell 20% of earnings (\$1.6M) to private equity. In turn, the "Post-Closing Synergy" column aims to add earnings back through revenue growth and expense efficiencies but recognizes it will need to fund capital returns as well.

\$ in Thousands	Hypothetical Practice				Notes
	"Run-Rate"	Normalized Phys. Comp	Post-Closing Synergy	Variance (C vs B)	
	A	B	C		
Financial					
FFS Revenue	\$ 48,000	\$ 48,000	\$ 48,960	2.0%	
Other Revenue	2,000	2,000	2,000	0.0%	
Total Revenue	50,000	50,000	50,960	1.9%	
<i>Assumed Professional Growth</i>			2%		Post-Transaction Synergy
Operating Expenses	42,000	42,000	41,580	-1.0%	
<i>Assumed Operating Efficiency</i>			1%		Post-Transaction Synergy
Earnings Before Physician Compensation (EBPC)	8,000	8,000	9,380	17.3%	
Physician Comp	8,000	6,400	7,504	17.3%	Results in income repair
<i>Level of Normalized Compensation</i>		80%			Normalizing compensation %
EBITDA	\$ -	\$ 1,600	\$ 1,876	17.3%	B = Impacts valuation; C = Payment for MSO

In this example, the post-transaction compensation pool available was approximately \$7.5M, with improved revenue and expense performance. Compensation systems will vary by specialty type and preference of the PE platform. Compensation models may include a Stark compliant revenue less expense model derived from EBPC for ancillary pool distributions. Or the models may include a more simplified version based on the percentage of professional net revenue or personally performed productivity (wRVUs). For the latter models, (percent of revenue or wRVUs), the underlying formula in this example would still likely target compensation of \$7.5M in the aggregate based on the delivered post-transaction synergies.

For anyone looking at physician alignment strategy, it is important to understand the options physicians are given under a PE compensation model. For assistance with [physician compensation model design](#), VMG Health has insight into all of the different models that have been evolving in the market, and critical factors to make them successful.

VMG Health is increasingly seeing strategies reflect an intersection between **private equity** and **health systems**.

Aligning & Differentiating Health Systems & Private Equity

Despite the benefits the PE model can offer to physicians, aligning with health systems can also be beneficial for physicians. Typically, health systems have longer strategic time horizons which allow them to employ physicians for longer terms. This can be a major benefit for physicians who are seeking stability. Additionally, health systems are often able to implement more unique compensation models that can better align with physicians' motivations. Finally, while most PE models focus on a single specialty, or a few related specialties, the physician who is aligned with a health system is often more integrated with physicians across a spectrum of specialties which can be intrinsically rewarding.

VMG Health is increasingly seeing strategies reflect an intersection between PE and health systems across several fronts including:

- Desire of health systems to be more competitive through the valuation of "synthetic EBITDA" where practices sell off excess earnings and are in turn paid upfront consideration. In most instances, this payment is subject to more favorable tax consequences.

- Using the valuation approach mentioned above, health systems are willing to take minority positions in an independent practice and essentially “joint venture” the synthetic EBITDA calculation. Often the health system attempts to bring its contract rates to the relationship.
- Following transactions of this form, health systems and independent practices consider establishing alignment across value-based care. This includes the development of Waiver Incentive Programs (WIPs) through an ACO, or a compensation arrangement qualified under the Value-Based Exception. In both instances, the successful management of cost and quality may lead to income and can assist the practice with income repair as part of selling compensation.
- Finally, there are examples of health systems joining directly in a regional MSO, or in an ambulatory strategy, along with a third-party investor where the health system participates in the underlying capitalization table of the PE platform. There are a lot of nuances as to whether this makes sense strategically, but nevertheless, it will be an increasing trend in 2023 and beyond.

As it relates to physician alignment, understanding the PE model is crucial for healthcare leaders. This understanding should encourage healthcare organizations to find innovative ways to align through new models. In the second half of 2023 and into 2024, VMG Health expects to see healthcare organizations aligning with PE companies, and/or considering a version of the PE model.

Key Takeaways

With the continued growth of PE companies entering the healthcare space, healthcare organizations should understand the PE play if they want to align with physicians as part of their growth strategy. The MSO model is different than a traditional employment model, or an independent contractor arrangement, but has proven to be attractive to physicians. When evaluating your organization’s physician alignment strategy, it is worth considering the benefits of this model and how to potentially partner with PE companies.

Physician Insight & Trends

Understanding physician compensation trends and top concerns are paramount to **physician alignment**.

Major Specialty Supply & Demand Trends

Survey Data Findings

To illustrate the most recent trends in physician compensation across all reported specialties, VMG Health has assessed the most recent year of compensation data reported in the 2023 Medical Group Management Associates (MGMA) provider compensation survey. Hospital and ancillary service-related specialties saw an increase in compensation of 1%, which is below the 1.9% expected growth rate and is a potential signal for an increase in financial constraints in hospital settings. Compensation for medical care specialties increased at a standard growth rate of around 2.5%, whereas surgical specialties had a lower overall year-over-year increase in physician compensation of 0.7%. Out of all specialties, compensation for primary care-related providers increased the most at an almost 4% increase compared to the corresponding 2022 survey. In terms of productivity (wRVUs), hospital and surgery-related specialties saw production remain relatively flat from 2022 to 2023. However, medical care and primary care specialties saw an overall increase in the reported wRVU production.

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The trends in the 2023 MGMA physician compensation data reflect changes that are consistent with insights highlighted in VMG Health's 2021 Physician Alignment Tips & Trends. Specifically, the insight that providing preventative care and outpatient services is expected to have a major role in healthcare services. While the survey data paints a clear picture of the trends moving forward in physician compensation, the following sections briefly discuss a few of the more nuanced specialties that VMG Health has experienced an increase in client interest over the past few years.

Neurointerventional Surgery

Over the last few years, VMG Health has seen increased demand for the recruitment of neurointerventional surgeons. This specialty is also known by a myriad of other names including neurointerventional radiology, endovascular neurosurgery, interventional neurology, and endovascular surgical neuroradiology. This is a relatively new, emerging specialty that incorporates components of neuroradiology, neurosurgery, and neurology while utilizing minimally

invasive approaches. According to the Society of NeuroInterventional Surgery, “neurointerventional surgery encompasses the practice of fluoroscopically guided endovascular procedures for pathologies involving the craniocervical and spinal regions, minimally invasive spinal procedures, and other percutaneous interventions of the head and neck.” As such, these physicians can effectively treat aneurysms, strokes, and vascular and spinal cord medical conditions in a growing number of patients.

The training pathway to become a neuro interventionalist requires a base specialty of radiology, neurology, or neurosurgery and each specialty requires a host of additional training. According to the Society of NeuroInterventional Surgery, there are approximately 730 neurointerventionalist in the United States making it one of the rarest and most specialized of the surgical specialties. Consequently, there is a shortage of physicians who are specialized in this field and are available to meet the ever-growing demand. In addition, there is limited market data available in the nationally published physician compensation and productivity survey data. This makes it difficult for health systems to offer physicians and effectively compensate them. Due to the low number of respondents to the surveys for this specialty, there is high variability in each reported metric year over year, posing an additional challenge. As a result, VMG Health has seen an influx of fair market value opinion requests for this specialty.

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Radiology

The American College of Radiologists (ACR) defines radiologists as “medical doctors that specialize in diagnosing and treating injuries and diseases using medical imaging (radiology) procedures (exams/tests) such as X-rays, computed tomography (CT), magnetic resonance imaging (MRI), nuclear medicine, positron emission tomography (PET) and ultrasound.” Radiology plays a vital role in the healthcare industry because it is often the starting point that leads to a variety of areas of care across the industry. The radiology industry is one that is heavily impacted by the physician shortage in the United States.

Demand for radiology services continues to outpace the supply of radiologists due to all the same reasons we see across physician specialties (e.g., aging Baby Boomers). The shortage is exacerbated by the lack of qualified physicians entering the workforce. A recent survey from the Society of Chairs of Academic Radiology/Association of Administrators in Academic Radiology found that roughly 53% of radiography programs, 59% of radiation therapy programs, and 32% of nuclear medicine programs are at capacity. Of note is the threat of artificial intelligence (AI) taking over radiologists’ jobs and instilling fears over job security. Further, the current work environment has led to high burnout rates which could also be a factor dampening the supply of new and existing radiologists.

One solution to fill the gaps in coverage has been the introduction of a remote-working model (i.e., teleradiology) that allows providers to conduct reads from home. Through this model, employers hope that more flexible work hours will ultimately reduce burnout rates. Unfortunately, even national teleradiology providers are experiencing increased difficulty in recruiting and retaining qualified physicians. Due to these market factors, VMG Health has observed an increase in valuation requests for coverage arrangements between hospitals/health systems and radiology practice providers, as well as anesthesia providers.

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Anesthesia

Consistent with population growth and an aging population, the demand for anesthesia services has increased across all healthcare settings. Meanwhile, Medicare reimbursement for anesthesia services has decreased from \$22,2730 per unit in 2019 to \$21,1249 in 2023 under the Medicare Physician Fee Schedule (MPFS). Revenue for anesthesia services experienced further suppression after the implementation of the No Surprises Act (NSA) and the independent dispute resolution (IDR) process. The NSA has led to unintended consequences for anesthesia providers, and the IDR has been used by payors to reduce reimbursement by refusing to go in-network with anesthesia providers. See the previous PATT section on page 8, “Handling the Coverage Agreement Surge Due to No Surprises Act” for more details.

The reduction in federal and commercial reimbursement for anesthesia services compounds the increased cost pressures faced by anesthesia providers, particularly as it relates to provider staffing costs. Based on a review of MGMA and AMGA’s most recent 2023 survey data, compensation for anesthesiologists has increased by 5.4%, and compensation for certified registered nurse anesthetists (CRNAs) has increased by 8.1% in the last 12 months; this growth significantly exceeds the inflationary trends we typically observe and compensation growth in other specialties. Upward pressure on provider compensation will likely continue in the short term as AMN Healthcare, a national search firm, reports anesthesia providers rank number one as the most requested searches. The confluence of decreased federal and commercial reimbursement amid increased compensation associated with staffing anesthesia providers is challenging independent anesthesiology groups and health system/ASC partners alike. As a result, VMG Health has been asked to assess anesthesia subsidy arrangements for ambulatory surgery centers (ASCs) and hospitals at an increasing rate.

Anesthesia providers rank number one as the most requested searches.

Cardiology

Over the past few years, VMG Health has experienced an influx of inquiries on how to handle the restructuring of compensation structures related to cardiology practices. VMG Health notes that general cardiology is one of the more difficult specialties to recruit because many physicians choose to focus on a specialized subspecialty within cardiology, rather than the general cardiology specialty title. In addition, VMG Health notes that general cardiologists often act as the gatekeepers of a cardiology practice responsible for the initial patient consultation. In this case, the general cardiologist would then refer the patient to a more specialized cardiologist within the practice. In this practice structure, it is common to see compensation structures set up as a “pooling” compensation model or a production share compensation model due to the flow of services. As such, VMG Health has seen an increase in requests to provide a comprehensive FMV review of cardiology practice compensation models due to the complex nature of cardiology practice dynamics.

Supply and demand challenges among specialties are important to consider when planning for recruitment and may lead to a [physician needs assessment](#). In addition, the data provided from surveys and other compensation resources are important when documenting [fair market value](#). Lastly, developing effective [compensation models](#) to attract hard-to-recruit specialties is an important part of the physician alignment strategy. VMG Health has in-depth experience related to the physician landscape and can assist with any services associated with strategy and compliance.

Tackling Key Physician Concerns

In this third edition of this report, our findings about the top physician concerns continue to be consistent as physicians continue to worry about the high levels of burnout within their industry. The World Health Organization has officially declared the end of the Global Public Health Emergency, but there has yet to be a positive change in the number of physicians who report they are burned out. In the most recent 2022 Physicians Foundation report, 62% of physicians stated they often have feelings of burnout. These feelings of burnout seem to continue due to the insurmountable administrative tasks, the gap in the perceived physician value and compensation, and the stigma physicians feel for seeking mental health treatment.

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Administrative Burden

Administrative burdens continue to be a source of burnout for physicians with common pre-pandemic strains related primarily to EHR documentation and increased prior authorization. However, the issue has worsened, and the 2022 Physicians Foundation report found most physicians reported staffing shortages as a challenge, and 85% of these physicians mentioned administrative burdens as a contributing factor to the staffing shortages. In addition, a 2022 MGMA stat poll stated 58% of those surveyed ranked staffing as the top challenge for medical practices. These surveys show how the administrative burden is not just felt by physicians, but also by their staff. If the administrative tasks and staffing issues are not addressed physicians will be left with the compiling workload as they try to provide quality care to their patients and adhere to the administrative requirements set by their organizations and payers. In addition, the staffing concerns will only exacerbate the burnout of current providers and could lead to more shortages as staff and physicians leave their field due to burnout.

Another factor that is increasing the administrative burden for physicians is the shift from fee-for-services to value-based care compensation structures since value-based care requires physicians to track and report on metrics. The 2022 Physicians Foundation report stated that 63% of primary care providers reported pay-for-performance measurement as a challenge. The growing number of administrative tasks are not feasible for physicians to take on as the average physician works 50 hours per week compared to the national average of 38.7 hours. Unfortunately, any additional time required on administrative tasks impedes the time physicians can spend on direct patient care.

Frustration with Physician Salaries

As physicians feel the strain of additional administrative workloads, there has been a concern about insufficient compensation by physicians. According to the Medscape 2023 Physician Burnout and Depression Report, 34% of physicians reported that insufficient compensation is a contributing factor to burnout. In addition, 20% of U.S.

physicians surveyed by Apollo Intelligence indicated that they hoped there would be improved pay for healthcare providers in 2023, but only 6% indicated that they thought an increase in compensation would be a reality. Medscape's 2022 to 2023 Physician Compensation Reports have indicated approximately a 4% increase in overall physician compensation. Despite this, physicians feel they are putting more hours into administrative duties imposed by payers and their organizations. At the same time, payers are decreasing reimbursement and health systems, but payers are not compensating for the time spent on these additional administrative tasks. As such, 45% of physicians reported that increased compensation would help the most with feelings of burnout. As administrative duties and the lack of workforce support continue to cause strain, physicians recognize financial compensation as a sign of value and appreciation by their healthcare organization which helps with the burdens they are experiencing.

Physician Mental Health Stigma

The last factor, and unquestionably the most alarming one related to physician burnout, is that 8 in 10 physicians agree there is a stigma with seeking mental health treatment. While physicians promote and encourage mental health treatment to their patients, physicians feel this is not accepted or welcomed within their medical community. This is demonstrated by only 13% of physicians seeking professional help for burnout. It is known in the medical community that a clear mental state is required to maintain licensing and credentialing certifications, so physicians may see seeking help or needing intensive treatment as a risk of losing their livelihood. The tragic consequence of failing to seek treatment is that 300 to 400 physicians die by suicide in the United States every year. This puts doctors at the highest suicide rate of any profession, followed by dentists, law enforcement, and veterinarians.

Burnout Relief and New Strategies

The factors that continue to keep burnout levels high for physicians are challenging and the solutions to mitigate burnout are not simple. In the past, we have outlined strategies taken by hospitals and health systems to address burnout, such as establishing wellness programs and appointing a chief wellness officer. However, the stigma physicians face in their occupation inhibits them from truly taking advantage of these resources. It will take a collaboration of physicians and health systems/healthcare organizations along with legislative and regulatory bodies to make real, impactful changes to tackle physician burnout.

One promising foundation that healthcare stakeholders can get involved with is the Dr. Lorna Breen Heroes' Foundation. This foundation urges hospitals, medical boards, and insurance companies to remove intrusive mental health questions from applications and licensures to help fight the stigma faced by physicians. Another way to be involved is by supporting the continuation of legislation such as the Dr. Lorna Breen Health Care Provider Protection Act that was passed on March 18, 2023. This act "is the first of its kind to allocate specific funds towards grants for training health profession students, residents, or health care professionals in evidence-informed strategies to reduce and prevent suicide, burnout, mental health conditions, and substance use disorders." Collaborative efforts to push legislation such as the above are the types of initiatives that hospitals and health systems should support to help drive the larger external changes needed to help mitigate physician burnout outside of internal efforts within their organizations.

While the implementation of these wider external changes around stigma will take time, there are potential solutions that can be used now to help alleviate burnout. This includes incorporating technology and flexible work schedules for physicians and support staff. The "Telehealth" section on page 5 of this report provides some important highlights about telehealth services to consider.

In addition, some physicians have indicated that an increase in compensation could help mitigate their feelings of burnout. Consulting with a VMG Health expert to value the services and expertise of the physician, including value-based care initiatives, could help justify an increase in compensation. Lastly, the use of advanced practice clinicians (APCs) and graduate medical education (GME) programs could assist with work-life balance, cost efficiencies and could provide an additional source for compensation.

Relieving Physician Shortages with APP & GME Supervision

It is well known that a growing and aging population is increasing the gap between physician demand and supply in the United States. A study published by the Association of American Medical Colleges (AAMC) indicates there will be a shortage of between 37,800 and 124,000 physicians by 2034. Some of the increased demand for healthcare services can be met by increasing utilization of nurse practitioners (NPs), physician assistants (PAs), and other advanced practice clinicians (APCs). Similarly, the utilization of medical school residents and fellows, along with a general expansion of the output of graduate medical education (GME) programs, may also help ease the physician shortage.

While many of these providers can operate relatively independently, physician supervision is often required to ensure high-quality patient care and favorable clinical outcomes. Many physicians expect to receive compensation for the time and effort dedicated to supervising APCs and teaching residents/fellows. This section will focus on strategies for compensating physicians for APC supervision and GME-related teaching services.

Compensating Physicians for APC Supervision

Evidence of APC utilization continuing to increase can be observed in the Bureau of Labor Statistics (BLS) Occupational Outlook Handbook which predicts PA jobs to increase by 28% through 2031, with 38,400 new positions estimated to be added. Jobs such as nurse anesthetists, nurse midwives, and NP roles are expected to grow by 40%, with 118,600 new positions to be created through 2031.

Since APCs can typically perform some of the same services as physicians at a significantly lower cost, they can increase economic efficiency and bottom-line profit for health systems and independent provider groups. This raises the question of how health systems and independent provider groups can compensate physicians for APC supervision services.

While the most obvious method of compensating a physician for APC supervision would be a time-based approach, it can be difficult to confirm an accurate assessment of the number of hours a physician provides supervision or assistance to APCs. The staggered nature of supervision services (five minutes here and there throughout the day reviewing charts, fielding questions, etc.) can make it challenging to accurately log time for these services. As such, it is more common to see compensation for supervision services via other methods, as further described below.

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Common APC Supervision Compensation Models

The following section addresses some common methods for compensating physicians for APC supervision services:

1.) Monthly or Annual Stipend

One of the most widely used methods is via an annual or monthly stipend. The stipend is often calculated based on the number of APC full-time equivalents (FTEs) the physician supervises. This yields a higher amount for physicians who oversee multiple APCs due to the assumption it would require a more significant time commitment from the supervising physician. Similarly, if two physicians share the supervision duties of one APC FTE, each physician's stipend would be less than that of a physician who is solely responsible for supervising one APC FTE.

2.) Share of APC wRVU Productivity

While compensating physicians for APC supervision services based on the supervised APC's wRVU productivity is less commonly observed in practice, this method can incentivize and reward physicians for operating a productive practice. Under this compensation method, a physician may receive a set dollar amount per work RVU produced by APCs under supervision. As a result, the physician's supervision compensation is tied to a variable measure of work product that offers the physician credit for APC productivity under supervision. However, it is recommended that the resulting maximum annual APC supervision compensation payments be capped at a reasonable level to avoid overpayment.

3.) Blended Stipend Plus wRVU Productivity

A blend of the two methods described above has also been observed in the market to compensate physicians for the base time spent providing general supervision while still offering incentives to operate a productive practice.

4.) Profit Allocation

Under an income-based approach, this method compensates physicians for APC supervision services based on a portion of the profits generated from the APC's professional services. This is calculated by subtracting all relevant expenses related to the APC's services from the professional collections generated by the supervised APC.

Potential Compliance Pitfalls

There are several scenarios in which compensating physicians for APC supervision could be inappropriate or viewed as duplicative of other compensation.

PSAs Where Group Is Paid for APC wRVUs:

In a professional services agreement in which the provider group is already compensated at a fair market value rate for wRVUs produced by APCs, paying a separate compensation amount to the group for APC supervision could be viewed as duplicative.

Time-Based Clinical Compensation:

Similarly, if a physician is compensated for clinical services via an annual salary based on their FTE status, then paying the physician incremental APC supervision compensation could be viewed as paying twice for the same hour of service. However, there is an exception if the supervision hours are above and beyond the physician's clinical FTE status.

Billing and Collection Rights:

In arrangements where a physician or physician group can bill and collect for APC clinical services, paying incremental APC supervision compensation could be viewed as duplicative. This is because the group/physician would already be receiving compensation (and potentially, profit) related to the productivity of the APCs.

Overlooking Indirect Expenses:

For income-based methodologies of APC supervision compensation, it is important for all expenses related to the APC's clinical services to be deducted before calculating physician compensation for APC supervision. If all necessary overhead expenses are not reflected in the expenses of the APC clinical services for calculation purposes this could lead to overpayment to the supervising physician.

Stacking Valuation Principles:

As APC supervision compensation becomes more commonplace in healthcare settings, especially in primary care specialties, valuation and physician compensation professionals must be aware that total cash compensation figures reported in surveys for the assessment of physician compensation may already include some amount of APC supervision compensation embedded in the data.

Common GME Supervision Compensation Models

GME refers to the period of training in a particular medical specialty (residency) or subspecialty (fellowship) following medical school. Residents and fellows undergoing GME typically require some form of oversight and proctoring by board-certified physicians. The physicians who supervise and train these students dedicate significant time and energy to the GME programs. However, determining how to compensate physicians for their supervision and teaching services can be a difficult exercise since physicians are often able to bill and collect, generate compensated wRVUS, or log hours towards their clinical compensation model while simultaneously teaching residents and fellows. The following section describes various ways of [compensating physicians participating in GME programs](#).

1.) Hourly Rate Method

One common method is via hourly rates. Hourly rates for GME teaching services are often bifurcated into two categories: 1) didactic/administrative hourly rates, and 2) direct supervision hourly rates.

- **Didactic/Administrative Hourly Rates:** Didactic/administrative hourly rates are typically paid for hours of teaching/GME administrative time when the physician is not simultaneously seeing patients and generating collections, wRVU credit, or other clinical compensation sources. These hours are often related to teaching time before and after clinic, resident and fellow recruiting, evaluation, program planning, lectures, case discussions, simulations, and general meetings. For administrative/didactic hours, a fully loaded fair market value (FMV) hourly rate commensurate with the physician's medical specialty can typically be paid, under the assumption the physician is not generating any other compensation during this time.
- **Direct Supervision Hourly Rates:** Conversely, direct supervision hourly rates are typically paid for hours when the physician is being shadowed by residents/fellows while simultaneously providing patient care. When supervising physicians round, perform procedures, or treat patients in a clinical setting, they may already be generating clinical compensation via professional collections, wRVU credit, time-based salary, etc. during the teaching time. As such, paying the supervising physician a full didactic/administrative hourly rate for the shadowing time could be interpreted as a double payment for the same hour of services. However, paying the supervising physicians an adjusted incremental hourly rate for the shadowing time may still be appropriate. This is due to the pauses

needed to explain concepts to shadowing students while simultaneously providing patient care which may cause a lag in clinical productivity and could result in the supervising physician generating fewer collections or wRVU-based compensation. For example, if the supervision of residents/fellows causes a 20% productivity lag for the proctoring physician during direct supervision hours, the physician could be paid 20% of a fully loaded teaching rate for the shadowing hours to account for the lost productivity that is incurred.

While productivity lags are often observed during direct supervision time, every GME situation is unique. In determining compensation for direct supervision hours, an analysis should be conducted to determine if a productivity lag exists. In some cases, more experienced residents or fellows can increase the productivity of the supervising physician if they are able to perform tasks independently and increase efficiency.

2.) wRVU Credit Method

As an alternative to the hourly rate method, VMG Health has observed hospitals increasing compensated physician wRVUs generated during direct supervision by the productivity lag percentage. In other words, if a physician independently produces 24 wRVUs per shift, but produces only 20 wRVUs per shift while being shadowed, the hospital could apply a 20% increase to wRVUs produced during a direct supervision shift. This would assign the proctoring physician credit for the estimated lost productivity incurred due to the teaching services provided.

3.) Stipend Per Full-Time Resident/Fellow Proctored Method

Under this compensation method, the physicians are paid a flat monthly or annual teaching rate for direct supervision services (and sometimes for didactic/administrative services) based on the number of residents or fellow FTEs the physician is directly responsible for. This method is often the easiest to administer, but it presents unique challenges in developing a fixed FMV rate without an assumption of the monthly physician teaching hours provided per resident FTE or the productivity lag (or lack thereof) for physicians who are also paid on wRVUs.

Conclusion

As the utilization of APCs and fellows/residents continues to increase in the healthcare industry, determining if and how to compensate physicians for supervision services will be a topic of discussion for health systems and independent provider groups. APCs and residents/fellows can offer significant value to health systems and independent providers by allowing physicians to allocate a higher portion of their time to more specialized services. In addition, compensating physicians for these additional services can make an existing compensation package more attractive. However, before paying physicians for supervision or teaching services, health systems should ensure the compensation arrangements are commercially reasonable and do not result in compensation that exceeds fair market value.

Understanding Value-Based Care Compensation Metrics

As the industry continues to move from volume to value, VMG Health is seeing a growing emphasis on organizations paying for value-based care (VBC). With this unwavering prominence of VBC in the market, more healthcare leaders are turning to physician alignment models to help maximize reimbursement from VBC contracts. Since physicians can help drive both savings and clinical quality outcomes, they can have a significant impact on VBC reimbursement.

There are already numerous alignment strategies in the VBC world in which health systems enter arrangements with physicians to improve clinical quality outcomes and/or cost efficiencies. In some cases, health systems are internally creating and self-funding these programs in anticipation of future changes to reimbursement. While in other cases, health systems eligible for incentive payments by third-party payors may want to share a portion of this incremental reimbursement/shared savings with the physicians who contributed to this achievement.

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Regardless of the path or the alignment strategy, generally, everyone wants to know, “How do we pay physicians for value-based care and how much can we pay them?”

Since there is no survey data that can really answer these questions, we believe it is important to first understand the full picture when creating a VBC program or establishing VBC payments to physicians. This requires a firm understanding of regulatory guidelines and payor models in the market which will help with proper alignment of strategy and compliance.

That said, with the variety of programs in the market and various underlying nuances for each program, sifting through this information to gain a thorough understanding of VBC compensation can be an overwhelming task. Conversely, taking an overly simplified or generic approach, such as pulling the median quality payment from survey data, may not be appropriate for every circumstance.

Therefore, VMG Health has broken down the “Top Six Fundamentals for VBC Compensation” every healthcare leader needs to know, regardless of how far along their organization is on its volume-to-value journey. These fundamentals are important to understand VBC compensation and work in aggregate to help establish support for a physician’s impact, enable the physician’s contribution to be properly measured and monitor progress, and reward the appropriate party for results.

The following walks through VMG Health’s “Top Six Fundamentals for Value-Based Care Compensation.”

1.) What is the Program Measuring?

The very first step is always to define what the program will measure in terms of the purpose, scope, and scale of the program:

- **Purpose:** Will your organization measure and generate payments based on patient clinical quality outcomes, cost savings, or both?
- **Scope:** Which specialties or providers will be eligible/offered to participate and will be critical to achieving the VBC goals?
- **Scale:** Will this program measure the personal performance of an individual physician, the performance of an entire service line, the performance of an entire patient population, etc.?

Once the goal and alignment strategy have been identified, it becomes easier to determine each of the following factors.

2.) Funding

Determining how the program will be funded is a critical component to understanding, structuring, and supporting VBC compensation to physicians. There are essentially three categories of how to describe a program’s source of funding:

- Internal or self-funded effectively from the hospital/health system facility revenue (Ex: A service line co-management program).
- Internal or self-funded effectively through shared savings (Ex: A budget-neutral program like a gainsharing arrangement related to certain cases).
- External or third-party funded effectively through incremental reimbursement or shared savings distributions from third-party payor contracts (these may also be referred to as “downstream” arrangements).

Generally, there is **more flexibility with VBC compensation payments** to physicians if the payments can be **tied to a third party**.

If the program is self-funded, there is generally more risk from a compliance perspective. Therefore, to help bolster support for the VBC compensation, self-funded programs may require more intense consideration of certain attributes of the subject program such as the specific performance metrics to be utilized.

3.) Performance Metrics

Another key factor that needs to be considered is having a substantive set of performance metrics. Defining and selecting the performance metrics are important for every arrangement, although as mentioned above, consideration of the performance metrics may carry more weight in some arrangements to help bolster support for the VBC compensation.

VMG Health collected industry research and identified multiple healthcare articles, publications, and other sources related to VBC bonuses paid to physicians and summarized value driver considerations related to the metrics below. While this list is not exhaustive, it provides the most common and important factors that support VBC compensation payments to physicians.

- **Metric Type:** Outcomes metrics are more valuable than process metrics.
- **Benchmark Endorsement:** Nationally endorsed benchmarks are more valuable than internal benchmarks.
- **Superior Performance Benchmark:** Establishing meaningful superior performance targets based on top decile performance are the most valuable targets.
- **Difficulty of Metric:** Stretch goals are more valuable than minor improvements and/or maintaining performance.
- **Number of Metrics:** Including a substantial number of meaningful metrics (usually 5–10 metrics).
- **Meaningful Metrics:** Selecting meaningful metrics based on the needs of the patient population or facility with supporting documentation for the clinical rationale.

Generally, factors such as paying for the achievement of “superior” performance standards and selecting patient clinical quality metrics that are demonstrably impacted by the subject physicians help justify higher VBC compensation payments.

4.) Risk & Responsibility

As mentioned above, it is critical for physicians to be instrumental in the achievement of performance metrics. This illustrates how the physicians (versus the hospital/health system) will have a direct, demonstrable impact on the metrics that will ultimately trigger VBC compensation payments.

While physician impact is key for bolstering support, it is also essential to understand the degree of responsibility of the non-physician entity (i.e., the hospital/health system). When payments are tied to quality and savings it is often clear the physicians have helped create those funds. That said, sometimes achievement of the VBC goals is driven by care coordination functions or other services not provided by the physicians and at the expense of the non-physician entity. Therefore, understanding which party is truly responsible for achieving the goals is critical from a compliance perspective.

It is typical for a health system, hospital, or other entity to provide certain services such as care coordination and IT infrastructure in arrangements that require robust infrastructure to achieve the VBC goals. As a result, it is important to consider both services and the costs incurred by the non-physician entity relative to those of the physicians in determining the right amount of VBC compensation.

Further, it is important to note that the entity that takes on more risk may warrant more compensation, while those with limited risk may have limited upside potential. This concept is becoming more prevalent as the most recent regulation changes allow additional levels of protection for those entities entering partial-risk or full-risk arrangements. That said, careful consideration should still be taken in establishing VBC compensation to ensure the compensation levels remain both competitive and compliant.

5.) Stacking

Before stacking VBC compensation for any physician, it is best practice to consider the physician's professional compensation risk. This is especially relevant if the participating physicians are employed or if the physicians are compensated with a fixed/guaranteed compensation model (i.e., shift-based pay). Essentially, it is important to confirm that the professional compensation has been evaluated to be consistent with FMV and is commensurate with productivity **before** stacking on any additional compensation tied to VBC. In addition, it is important to confirm there are no overlapping or duplicative VBC compensation payments already included in their employment/professional services agreements.

If the physician's professional compensation is at-risk (i.e., billed fee for service, money/work relative value unit model, no fixed/guaranteed salary), stacking is usually not an issue since it can be assumed the physicians are paid at FMV as they are paid by third-party payors. This is usually the case with physicians who operate as independent contractors.

Finally, assuming survey data was utilized to derive the employed physician's professional compensation, it is important to note that survey data can inherently include VBC compensation. As a result, it may be necessary to make an adjustment to ensure there is no potential overlap or duplication of VBC compensation.

6.) Payment Structure

As the way organizations are reimbursed moves towards quality and other non-productivity-based metrics, how those organizations pay their physicians needs to evolve in similar ways. There are many ways organizations can structure and pay for VBC, but some of the most common ways tend to be:

- **Flat Dollar Approach:** Under this approach, everyone within an organization has the same quality opportunity (e.g., \$20,000) regardless of that physician's subspecialty area.

- **Specialty-Specific Flat Dollar Approach:** Under this approach, each physician within a specialty would have the same opportunity. Typically, this is implemented as a percentage of a market median (as an example) so that every specialty has the same opportunity relative to their level of subspecialty compensation (e.g., FP gets 5% which may be \$25k, orthopedics gets 5% which may be \$50k).
- **Percent of Base Salary Approach:** Some organizations differentiate base salary levels by certain factors (years of experience/service, historical productivity, etc.). This approach ties a percentage of a physician's salary to quality by recognizing that physicians within a specialty may have different base salaries for a multitude of reasons, but that they should all have the same relative opportunity (e.g., 5% of base salary).
- **Productivity Approach:** This model is like the example used above (the \$45, \$50, or \$60 per wRVU example), and differentiates quality by individual based on their productivity such that a higher producer within a specialty will have a higher level of quality opportunity than a lower producer.

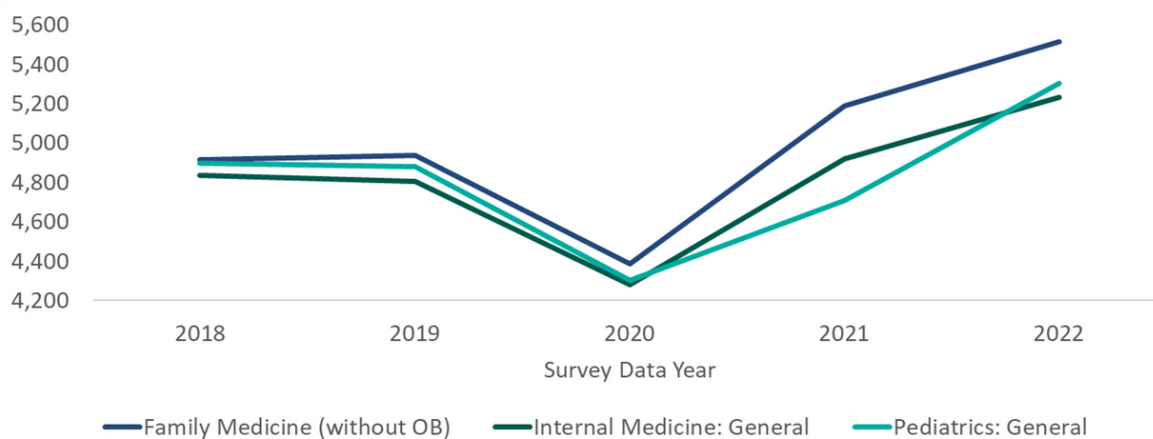
Keep in mind there is no right or wrong approach to the above. An organization must consider its compensation philosophy and guiding principles around provider compensation to determine an approach that aligns with the culture, mission, vision, and values of the organization as well as the VBC goals of the program. That said, the fair market value standard remains critically important to maintain compliance when paying for quality metrics. Lastly, quality payments have proven to be more difficult to design and integrate into compensation models, but if done properly they can be a game changer for physician alignment and better outcomes.

Designing Compensation Models for the Future

Benchmark Surveys Are Re-Stabilizing, but Still Require Caution

In the 2021 edition of VMG Health's PATT Report, a crucial warning was issued about the potential impact of the coronavirus pandemic on healthcare organizations and its future implications. Throughout the pandemic, healthcare organizations faced significant disruptions in patient volumes which caused fluctuations in physician productivity and destabilized physician compensation models. To top this off, the 2021 Medicare Physician Fee Schedule effective January 2021 significantly changed the value of wRVUs for outpatient evaluation and management (E&M) services. This wreaked further havoc on productivity-based compensation models and forced organizations to figure out compensation strategies during a time of immense change and challenge.

Now in the middle of 2023, VMG Health is starting to observe more balanced data from the popular benchmark surveys. Our experts believe the industry's collective efforts to adjust and refine compensation practices post-pandemic have contributed to the increased stability and reliability of the market survey data. As an example, the figure below shows a trend of MGMA median wRVU values for primary care specialties that were significantly impacted by both COVID-19 and the 2021 Medicare Fee Schedule changes. As you can see, 2020 and 2021 (represented in the 2021-2022 surveys) showed significant anomalies as compared to prior years. And while the 2022 data (2023 survey) still displays more variation than pre-2020 values, the data appears to be converging towards a more stable trend that reflects the elevated values of the outpatient E&M codes.



Currently only the MGMA and AMGA surveys have been released for 2023. These surveys are starting to offer a clearer, more accurate representation of compensation trends and benchmarks for physician practices. VMG Health believes this increased stability will allow healthcare organizations to make better informed decisions when designing compensation packages, ensuring competitiveness, maintaining fairness, and creating sustainability in attracting and retaining top talent.

While the new benchmark surveys now align more closely with pre-pandemic data (when adjusted for the E&M changes), organizations must remain diligent in survey use to avoid over-compensating or under-compensating physicians.

Organizations should not simply implement new survey data without carefully considering, analyzing, and understanding the data by subspecialty to ensure compensation and productivity levels align with expectations around the market. As an example, some pediatric subspecialties continue to see lower-than-expected volume as measured by wRVU productivity. Organizations must understand whether these market values reflect the new “normal,” or whether they are still challenged by volume fluctuations or other factors.

As we move forward in this evolving healthcare landscape, organizations must continue to exercise caution, evaluate survey data thoughtfully, and remain responsive to the changing needs of their physicians. By doing so, they can create sustainable, equitable compensation practices that support both physicians and the organization’s long-term success.

Physician Compensation Implications of the 2023 Medicare Physician Fee Schedule

In 2021, the Centers for Medicare and Medicaid Services (CMS) implemented substantial revisions to the Physician Fee Schedule (PFS), which had a notable impact on physician reimbursement and work relative value units (wRVUs) across different specialties in the outpatient setting. Building on those changes, in 2023 CMS introduced similar updates to the inpatient side and further influenced physician reimbursement and wRVUs within hospital settings.

The 2023 PFS Final Rule, published in November 2022, includes further modifications to Evaluation and Management (E&M) code guidelines aimed at reducing administrative burdens in inpatient settings and skilled nursing facilities. These revisions have had and will continue to have wide-ranging effects on E&M CPT code documentation requirements, wRVU values, reimbursement rates, and wRVU production levels for physicians and advanced practice providers (APPs) working in these settings.

Initially, the 2023 PFS set the Medicare conversion factor at \$33.06 and indicated a 4.5% decrease from the previous year's factor of \$34.61 to maintain budget neutrality. However, the Consolidated Appropriations Act of 2023, signed into law on December 29, 2022, provided additional funding for physicians and APPs serving Medicare beneficiaries. As a result, the final 2023 Medicare conversion factor was set at \$33.89 per RVU, representing a smaller 2.1% (\$0.72) reduction compared to 2022. Apart from E&M coding and reimbursement changes, certain specialties will experience more significant impacts, such as the increase in reimbursement and wRVU values for immunization administration. This change will particularly affect pediatric physicians and APPs due to the higher volume of immunizations administered to their patients.

The 2.1% reduction in the 2023 Medicare conversion factor will affect Medicare reimbursement across all specialties in 2023. This could potentially result in an impact on the financial feasibility of provider compensation plans, especially those incorporating wRVU productivity incentives in inpatient and skilled nursing facility settings. The 2023 MPFS deferred implementation of changes related to split-shared visits until 2024, and the proposed 2024 rule will further delay these changes until 2025 at the earliest. This will give health systems some much-needed relief as they continue to understand the impact these changes will have on both revenue and provider wRVUs for both physicians and APPs.

Looking ahead to 2024, the Centers for Medicare & Medicaid Services (CMS) have proposed several significant changes to the Physician Fee Schedule (PFS) that will impact physician reimbursement and compensation plans. Although a few potential changes are summarized here, there are additional details in the previous section of this report, "2024 Expected Medicare Physician Fee Schedule Changes." The proposed rule for the calendar year 2024 suggests a 3.34% decrease in the conversion factor, reducing it to \$32.75 from \$33.89 in 2023. This decrease is primarily due to the expiration of the 2.5% statutory payment increase from 2023, a 1.25% statutory payment increase for 2024, a 0.00% conversion factor update under the Medicare Access and CHIP Reauthorization Act, and a -2.17% budget-neutrality adjustment.

Additionally, the CMS proposes delaying the implementation of its policy to define the substantive portion of a split (or shared) visit based on the amount of time spent by the billing practitioner. Under this policy, if a non-physician practitioner performed at least half of an evaluation and management visit and billed for it, Medicare would only pay 85% of the physician fee schedule rate. This delay offers health systems and providers more time to prepare for potential changes in reimbursement and compensation when this policy is implemented.

In conclusion, the changes introduced in the 2023 MPFS (and the preliminary 2024 MPFS) have significant implications for physician compensation, particularly in specialties heavily affected by the modifications to E&M CPT code wRVU values in inpatient settings and other facilities. As the market emphasizes financial stewardship, it is crucial for physician compensation professionals and health systems to stay informed and proactive in evaluating the impact of these changes on compensation plans. Any adjustments resulting from the 2023 changes should be carefully assessed for fair market value, commercial reasonableness, and ongoing sustainability and affordability. These anticipated CMS changes for 2024 may further influence reimbursement and compensation. If so, it will be essential for health systems and physician compensation professionals to remain vigilant and adaptable to ensure equitable physician compensation. Organizations can effectively navigate these changes and maintain financial equity in their compensation models by staying well-informed and proactive.

Continued Move Away from wRVUs

Given the significant impact to wRVUs in recent years, VMG Health is seeing an uptick in organizations that are looking to shift away from a singular focus on wRVUs to a broader approach for provider productivity. Outside the primary

care setting, we have seen organizations consider switching from wRVUs to collections, patient encounters/visits, or other access-based metrics as a replacement for, or supplement to, the wRVU portions of compensation plans.

In the primary care setting, we have seen an uptick in organizations looking to implement an acuity-adjusted patient panel size as an alternative productivity metric for providers managing their own independent panel of patients. As the industry continues to shift focus from volume to value-based care and population health management, VMG Health expects panel size to emerge as the predominant way to measure work effort in the primary care setting.

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An organization looking to adopt a panel-based compensation plan must carefully consider how it determines both raw panels (unique patient counts by primary care provider) as well as its acuity-adjustment methodology. This is important for ensuring accurate comparability to an external market benchmark. VMG Health has recently published thought leadership in the American Association for Provider Compensation Professionals' (AAPCP) [2023 Journal of Provider Compensation](#). In the publication, our experts give a detailed analysis of panel size with robust guidance for organizations on how to measure and how to acuity adjust panel size, which organizations are recommended to follow prior to putting panel size into their compensation plans.

Continued Impact of Fraud and Abuse Regulations, Including Value-Based Exceptions

Finally, one large factor organizations are considering as they design their 2024 compensation plans is compensation evaluation in the context of the value-based exemptions and safe harbors (together the "exemptions") introduced in the 2021 revisions to the Stark Law and Anti-Kickback Statute. If structured appropriately and legally, these exemptions allow for greater upside compensation potential for physicians and physician groups that willingly take on higher levels of risk in their remuneration formula when engaging in value-based activities. For physicians who take on meaningful downside risk (e.g., more than 10% of compensation is held at risk for performance), a higher level of compensation opportunity may be provided for achieving outcomes under value-based arrangements, and this compensation may be exempted from both FMV and commercial reasonableness risks.

The key caveat is these arrangements must be structured in a compliant manner. With that said, organizations must consult with their internal and/or external counsel to assess whether their potential arrangements meet the criteria for these new value-based exemptions. Compliance with the rules set forth in these exemptions is crucial for organizations seeking to take advantage of the potential benefits they offer. As organizations continue to navigate these evolving regulations, they must stay informed to ensure they align their compensation practices with the new value-based arrangements while adhering to the necessary legal guidelines.

Compensation Design Summary

The healthcare industry has seen a restabilization in benchmark surveys since the onset of the pandemic. The efforts of healthcare organizations to adapt and refine compensation practices post-pandemic have contributed to the increased stability and reliability of market survey data. This enhanced data now provides a clearer representation of compensation trends and benchmarks and allows organizations to make more informed decisions when designing compensation packages.

However, it is important to remain cautious when using survey data. Organizations should not blindly implement these findings without understanding the underlying risks, data trends, and the unique circumstances of their healthcare settings. Each organization's compensation strategy must be carefully tailored to address specific needs and challenges. The equilibrium achieved in physician compensation trends reflects the industry's commitment to align compensation with physician contributions and to foster a sense of equity and collaboration within the healthcare community. Moving forward, organizations must continue to exercise caution, thoughtfully evaluate survey data, and remain responsive to the ever-changing needs of their physicians. By doing so, they can create sustainable and equitable compensation practices that support both physicians and the long-term success of the organization.

Key Takeaways

To prepare your physician alignment strategy during the current physician shortage environment, it is important to understand in-demand specialties, top physician concerns, and the latest compensation models. Designing progressive compensation models requires a deep understanding of reimbursement trends and the way physicians work. Numerous new compensation model components should be considered to stay competitive in today's market. Some of the more innovative models that will help physician alignment include components such as quality metrics, APC supervision, and panel size.

The Latest in Regulatory Guidelines

Understanding OIG Settlements & Physician Compensation

An understanding of the current regulatory landscape is key to developing arrangements that are compliant and in line with all the guidance provided by the Office of Inspector General (OIG). It is crucial that the compensation paid to physicians follows applicable OIG guidance, laws, and regulations. In addition, physician compensation arrangements that are inconsistent with fair market value (FMV) continue to be a central focus for the OIG. This is evidenced by the OIG's statement from a recent settlement in July of 2022 against Weirton Medical Center:

“*Healthcare decisions should be based on patients' medical needs, not physicians' financial interests. The department will continue to investigate financial relationships that may improperly influence physician decision-making.*” – **Principal Deputy Assistant Attorney General Brian M. Boynton**

“Improper compensation arrangements between hospitals and physicians will not be tolerated. The U.S. Attorney's Office will be aggressive in its pursuit of those who violate the Stark Law...” – **U.S. Attorney William Ihlenfeld**

The following summarizes notable cases and themes of the settlements reached by the OIG in 2022 and the beginning of 2023.

Medical Director Arrangements

For several years, it has been commonplace for healthcare entities to enter arrangements with physicians for the provision of medical director services or other physician administrative services. Most often these contractual arrangements allow the facility owners/operators, and providers to focus on providing healthcare services to patients and allow for the contracted party to provide more focused, efficient administrative services. However, these services can also be subject to violations of AKS if not structured and monitored appropriately.

United States ex rel. Zappala, et al. v. Steward Health Care System LLC

In June of 2022, Steward Health Care System reached a settlement agreement to pay \$4.375 million to resolve an allegation. The allegation was the Good Samaritan Medical Center (GSMC), paid physicians of a separate physician practice, Brockton Urology Clinic, for medical directorship services at its Prostate Cancer Program that were ultimately not provided by the physicians from 2011 through 2017. In addition, Steward also disclosed an additional arrangement from 2010 through 2016 under which a physician was paid to provide post-acute medical director services that were ultimately not provided.

United States of America ex rel. Neyiris Orozco v. Shlomo Rehnitz, et al.

In June 2023, Alta Vista Healthcare & Wellness Centre, LLC (Alta) paid \$3.825 million to settle a whistleblower case that alleged it submitted false claims by paying kickbacks to physicians from 2009 through 2019. Alta gave physicians excessive gifts, including extravagant dinners, golf trips, limousine rides, massages, e-reader tablets, and gift cards. Separately, Alta paid these physicians monthly stipends of \$2,500 to \$4,000, purportedly for their services as medical directors. At least one purpose of the gifts and payments was to allegedly induce the physicians to refer patients to Alta. As part of the settlement announcement, United States Attorney Martin Estrada stated:

“*The administrators and beneficiaries of the Medicare and Medicaid programs expect that providers will make decisions based on sound medical judgment, not their personal self-interest,” said Estrada. “As this case demonstrates, our office will take decisive action to address allegations that medical providers are paying or receiving improper financial benefits that could impact care provided to patients.”*

Physician-Owned Business Acquisitions

The purchase of a physician-owned business is a key alignment strategy for many hospitals and health systems to help bolster their breadth of service offerings to patients and/or to expand the continuum of care for patients. However, there is also increased competition in the market for practice acquisitions between hospitals and private equity, with PE firms paying higher prices on average for physician practices. Unfortunately, acquisitions can also create a degree of compliance risk if not structured and valued properly.

Kuzma v. Northern Arizona Healthcare Corporation

In this district court case, Northern Arizona Healthcare Corp. (NAHC) allegedly paid above FMV for Summary Surgery and Recovery Care Center (Center). NAHC argued there was no violation because there had been an independent FMV performed by a valuation firm supporting the price paid. However, the valuation obtained by NAHC was found to be materially flawed and overestimated the value of the Center by approximately \$10 million. Specifically, the valuation was not updated with more recent financial data prior to closing, did not consider the most recent volume trends, allegedly relied upon center-provided information without adequate due diligence, and lacked external/internal review that may have caught these errors. The cautionary tale is this: the existence of a professional valuation provides no defense to an allegation regarding an Anti-Kickback Statute violation if the valuation is overstated. It is important that hospitals and health systems have a trusted valuation partner and work in conjunction with the valuation firm to ensure the facts and circumstances of the valuation is correct.

U.S ex rel. CKD Project LLC v. Fresenius Med Care Holdings, Inc.

In this case, a relator made allegations that Fresenius paid nephrologists for patient referrals through payment more than FMV for controlling interest in dialysis clinics owned by the nephrologists. Additionally, it was noted in some cases that over 90% of the purchase price was allocated to intangible assets such as goodwill. Ultimately, Fresenius was able to obtain a dismissal of the case and noted these joint ventures were disclosed in securities filings.

Speaker Arrangements

Speaker fees and speaker programs have been a recurrent theme in the OIG's recent settlements and the past year was no exception, especially for laboratory, drug, and device companies. In November 2020, the OIG issued a Special Fraud Alert for Speaker Programs, which stated:

“OIG is skeptical about the educational value of such programs. Our investigations have revealed that, often, HCPs receive generous compensation to speak at programs offered under circumstances that are not conducive to learning or to speak to audience members who have no legitimate reason to attend. Such cases strongly suggest that one purpose of the remuneration to the HCP speaker and attendees is to induce or reward referrals.”

United States ex rel. Bawduniak v. Biogen Idec, Inc.

In September 2022, Biogen agreed to pay \$900 million to resolve allegations in a whistleblower case filed by a former employee. The allegation was that Biogen caused the submission of false Medicare and Medicaid claims by paying kickbacks to physicians. The employee alleged Biogen paid physicians who attended Biogen events in the form of speaking fees, speaker training fees, consulting fees, and meals to induce them to prescribe Biogen drugs.

Feel Well Health Center of Southington, PC; Kevin P. Greene, MD

In November 2022, the Feel Well Health Center of Southington, P.C., and Kevin P. Greene, M.D. agreed to pay more than \$2.6 million to resolve allegations that they violated FCA by improperly billing Medicare and Medicaid and received illegal kickbacks. Under the alleged scheme, Greene and Feel Well received remuneration in the form of processing/handling fees and speaker fees more than FMV from Boston Heart Diagnostic Corp. in return for ordering clinical laboratory services from the company for their Medicare patients.

Indirect Remuneration

The OIG also continues to focus on arrangements including indirect remuneration such as payment for renting space by and from physicians.

BioReference Health, LLC and OPKO Health, Inc.

In June 2022, BioReference Health, LLC (BRH) and OPKO Health, Inc. (OPKO) agreed to pay \$9.85 million to resolve allegations that BRH rented space at a rental rate above FMV from groups for its collection stations. In assessing the rental payments internally, BRH allegedly considered referrals generated from physicians when determining whether to rent space from or near the physicians. Furthermore, BRH incorrectly calculated the square footage to be leased and internal audits identified the rental payments exceeded FMV.

The OIG released a Special Fraud Alert in 2000 for the “Rental of Space in Physician Offices by Persons or Entities to Which Physicians Refer,” which noted questionable features of suspect rental arrangements included “the appropriateness of rental agreements, the rental amounts, and time and space considerations.”

Catholic Medical Center

In February 2022, Catholic Medical Center (CMC) agreed to pay \$3.8 million to resolve allegations that it violated the AKS by providing free on-call coverage to a cardiologist to induce referrals. Under the arrangement, CMC paid its

employed cardiologists to provide call coverage services to said cardiologist's patients when they were on vacation, or otherwise unavailable, free of charge.

Private Equity

As the rate of private equity interest and investment in the healthcare industry continues to rise, the OIG has increased scrutiny of these arrangements in lockstep.

U.S. ex rel. Martino Fleming v. South Bay Medical Health Ctrs.

A private equity firm and South Bay Mental Health Center, Inc (SBMHC) agreed to pay \$25 million to resolve allegations of causing false claims to Medicaid for mental health services. The violations included that these services were provided to patients by unlicensed, unsupervised, or otherwise unqualified staff. It was also alleged that the private equity firm and executives at SBHMC knew of the unqualified staff providing services but failed to address and/or correct the wrongdoing.

U.S. ex rel. Mandalapu v. Alliance Family of Companies, Inc.

In 2021, Alliance Family of Companies LLC (AFC), an electroencephalography company, agreed to pay \$13.5 million to resolve allegations from a whistleblower that it induced physicians to order EEGs from AFC by "providing kickbacks in the form of free EEG test-interpretation reports, thereby enabling primary care physicians who were not neurologists to bill the government as if they had interpreted the tests." The OIG alleged that Ancor, the private equity firm backing AFC, uncovered the kickback scheme during its acquisition due diligence and allowed the scheme to continue once acquired. AFC entered into a five-year corporate integrity agreement with the OIG.

The federal government continues to focus on lowering the cost of healthcare and providing remuneration to physicians has always been an area of investigation. When healthcare leaders are developing a physician alignment strategy, ensuring physician arrangements are consistent with fair market value and are commercially reasonable are key aspects to consider. It is also important to recognize less obvious arrangements, such as indirect compensation and real estate arrangements, which are also the subject of recent scrutiny.

Top Coding Targets

2023 E/M Impact on Providers

The 2023 Evaluation and Management (E/M) coding guidelines have had a significant impact on physicians and advanced practice providers (APPs) such as physician assistants (PA) and nurse practitioners (NP). The previous guidelines (1995/1997 E/M Documentation Guidelines) were in place for over 25 years. These changes were first implemented in 2021 to streamline the documentation and coding process and to reduce the administrative burden on providers in the office/outpatient setting only. Subsequently, the new guidelines that took place in 2021 were extended to all places and categories of service (Office/outpatient, inpatient, nursing home, new and established, initial and subsequent) on January 1, 2023.

A few key impacts:

- **Documentation Requirements:** The new guidelines emphasize medical decision-making (MDM) and time spent. History and physical examination documentation no longer impact the level of service.
- **Coding Levels:** Providers are now required to meet a minimum threshold for MDM or time spent to determine the level of service, simplifying the process.
- **Time:** The new guidelines place greater emphasis on patient care. Providers may now select the E/M code level based on the total time spent on the date of encounter, including both face-to-face and non-face-to-face activities.

This has been an adjustment period for providers regarding the nuances of the guidelines and associated documentation requirements. Provider, coder, and billing staff education is recommended. EMR templates and smart phrases or macros require updates to meet the new documentation requirements. Baseline post-change audits and provider feedback are recommended to ensure that documentation and coding are on track.

While long-term improvement in efficiency and accuracy in documentation and coding practices is the expected outcome, additional time and effort will be needed to achieve this outcome.

Medical Necessity

The American Medical Association (AMA) defines medical necessity as “health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or, its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the convenience of the patient, physician, or other health care provider.

The Center for Medicare and Medicaid Services (CMS) sets medical necessity requirements for providers to ensure that services are reasonable, necessary, and appropriate. CMS typically evaluates whether a service or treatment:

- Is consistent with the patient’s diagnosis, symptoms, and condition
- Is necessary for the diagnosis or treatment of an illness, injury, or condition

Provider documentation should demonstrate the medical rationale and should support the need for the services provided. Providers must stay informed about CMS guidelines and updates. Medicare coverage determinations, both local (LCD) and national (NCD), define Medicare’s coverage requirements for services including indications, limitations, and billing and coding guidance. Coverage determinations are updated regularly, and providers need to keep abreast of the changes to ensure they are meeting current guideline requirements.

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High-Risk Modifiers: -25 and -59

Over the years, misuse and misunderstanding of modifiers -25 and -59 have led to carrier audits and scrutiny by the OIG. The OIG has issued reports highlighting the erroneous application of these modifiers and the instances of intentional and unintentional fraud by providers.

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In general, E/M on the same day as a procedure is included in the procedure and not separately reportable/reimbursable (including the decision to perform a minor procedure). To avoid overuse or misuse of modifier -25 and to reduce the risk of audit:

1. Verify National Correct Coding Initiative (NCCI) bundling edits before submitting modifier -25.
2. Do not automatically report an E/M code every time a minor procedure is performed.
3. Documentation should clearly support the medical necessity for both E/M and same-day procedure or service.
4. Different diagnoses are not required to report the E/M service on the same date as the procedure or other service.

Modifier 59 (distinct procedural service) continues to be the most used and abused modifier. As a result, modifier -59 continues to be a high-risk audit area. This modifier is used to identify non-E&M services which are not typically reported together but are provided under appropriate circumstances. Documentation is required that supports a separate session, procedure, surgery, excision, lesion, or injury, that is not routinely encountered on the same day by the same provider. When this is done inappropriately, it is often referred to as “unbundling.”

Modifier -59 correct use strategies include:

- Keep up with the National Correct Coding Initiative (NCCI) quarterly updates.
- Verify National Correct Coding Initiative (NCCI) bundling edits before submitting modifier -59.
- Educate providers, coders, and billing staff regarding the appropriate use of modifier -59 and associated documentation requirements.
- Avoid hard-coding modifier -59 in EMR/billing software.

Shared/Split E/M Guidelines:

In 2022, CMS introduced changes to the shared/split E/M guidelines. A shared/split visit is an E/M service performed in part by a physician and an APP in a hospital or facility setting for a new or established patient, or for an initial or subsequent visit. Shared/split visits may not be provided in an office setting.

The 2022 changes defined applicable places of service, same group, and substantive portion. The guidelines outline the criteria to determine who should report the service – physician or APP. The substantive portion, except for critical care services which are defined solely by time, is defined as one of the three key E/M components (history, physical, examination, MDM), or more than one-half the total time the physician and APP spend performing the shared/split service. Delayed until 2025, the substantive portion will be defined only as more than one-half the total time the physician and APP spend performing the shared/split service.

The medical record documentation must identify the two individual providers who performed the split/shared visit. The individual who performed the substantive portion, and therefore bills the visit, must sign and date the medical record. The combined physician and APP documentation determines the level of service. Modifier -FS is required to be appended to E/M service for split/shared visits.

Providers should be aware of the potential workflow and documentation changes that may be required to comply with the guideline changes. Split/shared E/M visits are no longer guaranteed at the higher physician reimbursement amount but are dependent on which provider renders the substantive portion of the visit instead. Documentation and provider education will be key elements for compliance.

Coding is obviously integral to how physicians operate and get reimbursed. Training is essential due to ongoing changes in coding guidance. Addressing top coding concerns will greatly enhance compliance, and in many cases optimize revenue.

Implementing Coding, Compliance, and Risk-Based Adjustments

Incorrect diagnosis reimbursement can occur when a patient's diagnosis is inaccurately coded or documented. This can lead to a discrepancy between the expected reimbursement and the actual reimbursement received by healthcare providers. ICD-10 codes and risk-based coding are ongoing areas of complexity for coding. The impact of incorrect diagnosis reimbursement can have several consequences such as:

- **Under-Reimbursement:** If a patient's diagnosis is not properly documented or coded, their case may be assigned a lower level of severity. As a result, the reimbursement may not fully reflect the resources and services provided by the healthcare provider. This can lead to financial losses and can negatively affect the provider's revenue.
- **Over-Reimbursement:** Conversely, incorrect diagnosis coding can also lead to over-reimbursement if a higher severity or more expensive diagnosis is assigned to the patient's case. This can occur due to coding errors, intentional upcoding, or inadequate documentation to support the assigned diagnosis. Over-reimbursement can result in potential legal and financial risks for healthcare providers if identified during audits or investigations.
- **Compliance and Audit Risks:** Incorrect diagnosis coding and documentation can raise compliance issues and increase the risk of audits by government payers, such as Medicare and Medicaid. Inaccurate or unsupported diagnoses may trigger investigations, penalties, or repayment demands if identified during these audits.
- **Quality Metrics and Reporting:** Inaccurate diagnosis coding can impact quality metrics and reporting. Diagnostic data is often used to measure healthcare outcomes, assess quality indicators, and generate performance reports. Incorrect diagnoses can distort these metrics which can lead to misleading assessments of the quality of care provided by healthcare providers.
- **Patient Care and Continuity:** Inaccurate diagnosis coding can have implications for patient care and continuity. It may result in incorrect treatment plans, inappropriate referrals, or delays in accessing necessary services. Patients may experience difficulties in receiving appropriate care if their diagnoses are not accurately captured and reflected in their medical records.

To mitigate the impact of reporting an incorrect diagnosis, healthcare providers should prioritize accurate and thorough documentation, ensure proper coding practices, and conduct regular [audits](#) to identify and rectify any coding errors. Ongoing education and training for healthcare providers and coders can also help improve coding accuracy and reduce reimbursement discrepancies.

ICD-10 Codes

Practices and providers should update their systems to reflect the annual October changes in ICD-10 codes.

Healthcare providers must comply with coding guidelines and regulations, and it is recommended to engage in continuous quality improvement efforts to enhance documentation practices and coding accuracy. A diagnosis should not be reported if it is not documented in the record on the date of service for which it is reported. For professional services, if a definitive diagnosis is not determined at the time of the patient's encounter the providers should report

signs and symptoms until a definitive diagnosis is determined. Remember, if you utilize a copy-and-paste feature for documentation in the electronic medical record only update the diagnosis for the problems addressed or the comorbidities associated with the patient's care on the date of service.

In all cases, documentation in the patient's medical record must support the medical necessity for services submitted (including the level of E/M service). It is best practice for physicians to evaluate their level of coding specificity and to ensure they are coding to the greatest level of detail that represents the patient's condition and is supported by the documentation of the encounter. Coding specificity includes reporting all diagnosis codes that identify the patient's condition. Reporting comorbidities impacting a patient's current diagnosis will demonstrate the necessity of the level of care provided.

ICD-10-CM guidelines also define acute, persistent, recurrent, and chronic for various diagnoses. CDC guidelines indicate to "code all documented conditions that coexist at the time of the encounter/visit and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment."

Common Diagnosis Coding Guidelines

- Do not report an undocumented diagnosis.
 - All diagnosis codes reported for the date of service must only be documented on that date of service.
- If the diagnosis is indicated as any of the following: probable, possible, r/o, vs, consistent with, compatible with, indicative, suggestive, hx of, suspicious, pending, presumed, signs of, questionable, perhaps, then the provider must code signs and symptoms until a definitive diagnosis is determined.
- Always document the site, chronicity, acuity, or staging of a condition.
- Establish the linkage of the relationship between two conditions.
 - Common linking words include with, due to, diabetic polyneuropathy, etc.
- Be cognizant of conflicting documentation.

Risk Adjustments

Risk-adjusted diagnosis coding is a model used to predict future healthcare costs based on demographics and diagnoses. CMS pays for Medicare Advantage (MA) plans using Hierarchical Condition Categories (HCCs) and the HCC model is used by many private payers and ACOs for risk adjustment. Briefly, Medicare pays MA plans more for patients with a higher disease burden, as measured by their risk score. The risk scores also include demographics and geographic location.

The disease burden of the population of patients being served is measured by the diagnosis codes that are submitted to the payer on the hospital and professional claim forms and in additional file submissions. The process resets on January 1 of every year.

Risk Adjustment is used to evaluate and compare **you** to your peers. Higher risk scores translate into higher premiums paid by the payor (CMS, etc.) to a contracted entity (ACO, health plan, etc.) for the patient's care.

Higher risk scores translate into **higher premiums** paid by the payor.

Looking at the quality measures of the patients attributed to you, the risk score allows for a more complete picture of the quality of patient care. Regarding the risk score, higher scores equate to more sickness. However, lower risk scores associated with high cost may indicate a provider is a poor clinical manager or has a poor ability to document the clinical picture.

Errors in reimbursement from a risk adjustment perspective can lead to inaccuracies or mistakes in the process of determining and calculating payments based on the risk profile of patients in a healthcare system. Risk adjustment is a method used by payers including Medicare Advantage plans, to adjust reimbursement rates based on the health status and predicted healthcare costs of the enrolled population.

Some common errors in reimbursement from a risk adjustment perspective include:

1. **Documentation Errors:** Inadequate or incomplete documentation of patients' diagnoses, conditions, and severity can lead to underreporting or misreporting of risk scores, resulting in lower reimbursement than what should be received.
2. **Coding Errors:** Incorrect assignment of diagnosis codes or procedure codes can impact the accuracy of risk scores and subsequent reimbursement. This may occur due to coding errors, insufficient knowledge of coding guidelines, or insufficient documentation to support the assigned codes.
3. **Upcoding or Down coding:** Intentionally or unintentionally assigning diagnosis codes that do not accurately reflect the patient's health status can lead to inappropriate risk scores and reimbursement. Upcoding involves assigning higher-severity codes than those supported by the patient's condition, while down coding involves assigning lower-severity codes to reduce risk scores and reimbursement.
4. **Data Inconsistencies:** Inaccurate or inconsistent data reported to the risk adjustment system can result in errors in calculating risk scores and subsequent reimbursement. This may occur due to data entry mistakes, system errors, or discrepancies between different sources of patient information.
5. **Inadequate Hierarchical Condition Category (HCC) Capture:** HCCs are specific diagnosis codes used in risk adjustment models. The failure to identify and document all relevant HCCs for a patient can result in an underestimation of the patient's risk score and the corresponding reimbursement.
6. **Lack of Provider Education and Training:** Insufficient knowledge and understanding of risk adjustment methodologies, coding guidelines, and documentation requirements among healthcare providers can contribute to errors in reimbursement.

It is important to ensure accurate and comprehensive documentation, proper coding practices, and regular auditing and monitoring of coding and documentation processes. In addition, ongoing education and training for providers and coders, along with adherence to payer-specific guidelines and regulations, should be part of any healthcare organization's [compliance program](#).

Historically, the process was submitting CPT and ICD diagnosis codes on claims to validate reimbursement for services already rendered. In risk adjustment payment models, submitted I-10 codes that risk adjust will be used by a payer to calculate each patient's risk adjustment score. These scores will determine the projected "spending budget" and prospective payments during the coming calendar year. Profitability or losses will depend on the net difference between risk-adjusted payments and actual utilization costs for the care rendered. In other words, CPT/HCPCS codes submitted on a claim to a payer have been a financial transactional event (e.g., invoice for payment(s) based on services/procedures already rendered).

Going forward, value-based payments will continue to be driven by I-10 risk adjustment coding combined with CPT/HCPCS compliant coding.

Based on OIG audits, CMS has come to believe there has been upcoding by MA plans in recent years. And naturally, they have implemented changes for 2024. CMS is finalizing changes to risk adjustment models with the goal of better-predicting plan liability for certain subpopulations. CMS has also finalized refinements to the HHS Risk Adjustment Data Validation (HHS-RADV) to better align the calculation and application of error rates with the intent of the program. The RADV process validates data collected from insurers to ensure that risk adjustment transfers are accurate. It's worth noting that the specific errors and their impact on reimbursement can vary depending on the healthcare system, payer requirements, and the specific risk adjustment model being used.

Value-based payment arrangements make it crucial for healthcare providers to comply with coding guidelines and regulations, and to engage in continuous quality improvement efforts to enhance documentation practices and coding accuracy. In addition to compliance, this practice can also be an avenue for reimbursement optimization. As a result, understanding risk-based coding guidance is important for both staff and physicians to understand.

DOJ's Updated Evaluation of Corporate Compliance Programs

In May 2023, the Department of Justice (DOJ) made significant changes to the Evaluation of Corporate Compliance Programs (ECCP). Key takeaways from the latest updates are the DOJ's continued emphasis on (1) compensation structures that incentivize compliance and punish misconduct (Pilot Program) and (2) compliance policies and procedures that relate to the use of messaging applications, ephemeral messages, other communications platforms, and personal devices.

Compensation Policies

One of the revisions in the ECCP includes specific language that addresses compensation structures and the roles they play in "fostering a compliance culture." Prosecutors can now consider several factors when evaluating corporate compliance programs and potential resolutions including areas such as:

- Compensation incentives for employees that demonstrate commitment to complying with compliance processes.
- Recoupment or reduction of compensation when there is misconduct or violations of compliance policies.

DOJ's Pilot Program is a three-year initiative that focuses on compensation incentives and clawbacks starting on March 15, 2023. There are two primary components:

1.) Corporate Compensation Structures: There must be certain compliance-related criteria in the company's compensation and bonus system. The Pilot Program suggests criteria could include:

- A prohibition on bonuses for employees who do not satisfy compliance performance requirements.
- Disciplinary measures for employees who violate applicable law and others who both (i) had supervisory authority over the employee(s) or business area engaged in the misconduct, and (ii) knew of, or were willfully blind to, the misconduct.
- Incentives for employees who demonstrate full commitment to compliance processes.

2.) Clawback Compensation: Fine reductions will be offered to companies that seek clawback compensation from employees who engage in misconduct, had supervisory authority over the employee(s) or a business unit that engaged in the misconduct, or who were willfully blind to the misconduct.

These changes to the ECCP and implementation of the Pilot Program are a part of the DOJ's efforts to increase "individual accountability," including employees who have supervisory authority over employees and business areas that engage in misconduct.

Personal Devices and Messaging Applications

Another revision in the ECCP addresses corporations' approaches to the use of personal devices and messaging applications. The DOJ expects changes to companies' policies and procedures that govern the use of personal devices, communication platforms, and messaging applications. These policies should be tailored to the company's risk profile and specific business needs. Prosecutors are instructed to consider how employees are informed about the company's communication platform-related policies and procedures, and whether the policies and procedures are enforced regularly and consistently.

The ECCP also contained questions for prosecutors to address when evaluating a company's policy. These questions include whether the company allows employees to review business communication on personal devices and/or messaging applications; and whether employees are required to transfer messages from messaging applications to a recordkeeping system within the company to preserve and retain those messages. Prosecutors are also advised to consider and evaluate whether the company has any disciplinary actions for employees who refuse to provide access to business data on their personal devices.

In summary, companies should devote time and resources to ensure existing policies address the changes relating to communication channels and platforms, compensation structures, and appropriate disciplinary actions. Healthcare leaders should understand the importance of compliance in all areas of physician alignment whether it be related to training, coding, or compensation since it is their responsibility and risk.

Key Takeaways

Healthcare's highly regulated environment is an area that all healthcare leaders need to understand. Recent case law and OIG opinions provide a roadmap for how physician arrangements will be scrutinized. Further, the latest coding guidance and the DOJ's initiatives will help leaders ensure their compliance program is up to date. Lastly, notable areas for compliance efforts to focus on will be physician compensation matters and proper coding.

References

- Accreditation Council for Graduate Medical Education. (2023). About the ACGME. <https://www.acgme.org/About-Us/Overview/>
- Adler, L., Fiedler, M., Ginsburg, P., Hall, M., Ippolito, B., & Trish, E. (2021, February 4). Understanding the No Surprises Act. Brookings Institute. <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2021/02/04/understanding-the-no-surprises-act/>
- American College of Radiology. (2023). What Is a Radiologist? <https://www.acr.org/Practice-Management-Quality-Informatics/Practice-Toolkit/Patient-Resources/About-Radiology>
- American Counseling Association. (2022). ACA Government Affairs and Public Policy: 2022 Year End Report. www.counseling.org/docs/default-source/government-affairs/gapp-2022-year-end-report.pdf?sfvrsn=6527342c_2
- American Medical Association. (2020, April 27). Cares Act: AMA COVID-19 pandemic telehealth fact sheet. <https://www.ama-assn.org/delivering-care/public-health/cares-act-ama-covid-19-pandemic-telehealth-fact-sheet>
- American Society of Anesthesiologists. (2023, July 13). Broken Medicare System Results in CMS Proposing Reduced Physician Payments in 2024. <https://www.asahq.org/advocacy-and-asapac/fda-and-washington-alerts/washington-alerts/2023/07/broken-medicare-system-results-in-cms-proposing-reduced-physician-payments-in-2024>
- American Society of Radiologic Technologists. (January 2021). Enrollment Snapshot of Radiography, Radiation Therapy, and Nuclear Medicine Technology Programs - 2020. <https://www.asrt.org/docs/default-source/research/enrollment-snapshot/enrollment-snapshot-of-radiography-radiation-therapy-and-nuclear-medicine-technology-programs-2020.pdf>
- AMN Healthcare. (2023). 2023 Review of Physician and Advanced Practitioner Recruiting Incentives. <https://www.amnhealthcare.com/siteassets/amn-insights/blog/physician/2023physicianincentivereview.pdf>
- Andrew, L. (2022, July 13). Physician Suicide. Medscape. <https://emedicine.medscape.com/article/806779-overview>
- Apollo Intelligence. (2023, February 15). The 8th Annual Apollo Global Healthcare Predictions. <https://apollointelligence.net/wp-content/uploads/2023/02/2023-Apollo-Healthcare-Predictions-Report2.16.23.pdf>
- ATA Action. (2023, January 18). ATA Action 2023 State Legislative Priorities. www.americantelemed.org/wp-content/uploads/2023/01/Public-State-Legislative-Tracker-1.18.23-002.pdf.
- Bass, Berry & Sims. (2022). 11th Annual Healthcare Fraud & Abuse Review. <https://www.bassberry.com/fraudinhealthcare/>
- Bestsenyy, O., Gilbert, G., Harris, A., and Rost, J. (2021, July 9). Telehealth: A quarter-trillion-dollar post-COVID-19 reality? McKinsey & Company. www.mckinsey.com/industries/healthcare/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality
- Boyle, P. (2020, June 26). U.S. physician shortage growing. Association of American Medical Colleges. <https://www.aamc.org/news/us-physician-shortage-growing>
- Centers for Medicare and Medicaid Services. (2023, April 1). ICD-10-CM Official Guidelines for Coding and Reporting. <https://www.cms.gov/files/document/fy-2023-icd-10-cm-coding-guidelines-updated-01/11/2023.pdf>
- Centers for Medicare & Medicaid Services. (2020, March 17). Medicare Telemedicine Health Care Provider Fact Sheet. www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet
- Coward, E.L. and Threlkeld, R. (2022, June 24). New Federal District Court Opinion Offers Cautionary Analysis For Hospital And Physician Group Transactions. <https://www.mmmlaw.com/media/new-federal-district-court-opinion-offers-cautionary-analysis-for-hospital-and-physician-group-transactions/>
- Dr. Lorna Breen Foundation. (2022, February 17). Dr. Lorna Breen Heroes' Foundation Hails Senate Passage of Legislation Protecting Healthcare Workers' Mental Health. <https://drlornabreen.org/we-did-it/>
- Dr. Lorna Breen Foundation. (2023, March 18). Statement on Removing Intrusive Mental Health Questions from Hospital Credentialing Applications from the Dr. Lorna Breen Heroes' Foundation and the National Institute for Occupational Safety and Health. <https://drlornabreen.org/we-did-it/>
- Gibson Dunn. (2023, March 14). DOJ Updates Its Guidance on Corporate Compliance Programs. <https://www.gibsondunn.com/wp-content/uploads/2023/03/doj-updates-its-guidance-on-corporate-compliance-programs.pdf>
- Harrop, C. (2022, September 21). Healthcare in 2023: Staffing is still the biggest challenge for practices as financial worries grow. Medical Group Management Association. <https://www.mgma.com/mgma-stats/healthcare-in-2023-staffing-is-still-the-biggest-challenge-for-practices-as-financial-worries-grow>
- H.R.4040 - 117th Congress (2021-2022): Advancing Telehealth Beyond COVID-19 Act of 2021. (2022, July 28). www.congress.gov/bill/117th-congress/house-bill/4040.
- H.R.1110 - 118th Congress (2023-2024): KEEP Telehealth Options Act of 2023. (2023, March 3). www.congress.gov/bill/118th-congress/house-bill/1110.

References

- Joshua York Legacy Foundation. (2023, March 16). Highest Suicide Rate By Profession: What We Can Do To Reduce Suicide Rates Significantly. <https://www.joshuayorkfoundation.org/blog/highest-suicide-rate-by-profession/>
- Kane, C., and Gillis, K. (2018). The Use Of Telemedicine By Physicians: Still The Exception Rather Than The Rule. Health affairs (Project Hope) 37(12) (2018): 1923-1930. <https://doi.org/10.1377/hlthaff.2018.05077>
- KFF. (2021, February 4). Surprise Medical Bills: New Protections for Consumers Take Effect in 2022. <https://www.kff.org/private-insurance/fact-sheet/surprise-medical-bills-new-protections-for-consumers-take-effect-in-2022/>
- Medscape. (2022). 2022 Physician Compensation Report. <https://www.medscape.com/slideshow/2022-compensation-overview-6015043#2>
- Medscape. (2023). 2023 Physician Compensation Report. <https://www.medscape.com/slideshow/2023-compensation-overview-6016341#18>
- Medscape. (2023). US Physician Burnout & Depression Report. https://www.medscape.com/slideshow/2023-lifestyle-burnout-6016058?icd=login_success_email_match_norm#6
- Murphy, J. P., André, J. L., and Walters, S. E. (2023, April 10). DOJ Announces Changes to Corporate Compliance Program Evaluation Criteria. McDermott Will & Emery LLP. <https://corpgov.law.harvard.edu/2023/04/10/doj-announces-changes-to-corporate-compliance-program-evaluation-criteria/>
- Newitt, P. (2022, December 22). No Surprises Act is hurting anesthesia reimbursements, CEO says. Becker's ASC Review. <https://www.beckersasc.com/anesthesia/no-surprises-act-hurting-anesthesia-reimbursements-ceo-says.html>
- Newitt, P. (2022, September 16). The downsides to the No Surprises Act's dispute resolution process. Becker's ASC Review. <https://www.beckersasc.com/anesthesia/the-downsides-to-the-no-surprises-act-s-dispute-resolution-process.html>
- Office of the Attorney General. (2021, October 14). Private Equity Firm and Former Mental Health Center Executives Pay \$25 Million Over Alleged False Claims Submitted for Unlicensed and Unsupervised Patient Care. <https://www.mass.gov/news/private-equity-firm-and-former-mental-health-center-executives-pay-25-million-over-alleged-false-claims-submitted-for-unlicensed-and-unsupervised-patient-care>
- Office of Inspector General. (2000). Special Fraud Alert. https://oig.hhs.gov/documents/special-fraud-alerts/871/office_space.htm
- Office of Inspector General. (2020, November 16). Special Fraud Alert: Speaker Programs. <https://oig.hhs.gov/documents/special-fraud-alerts/865/SpecialFraudAlertSpeakerPrograms.pdf>
- Office of Public Affairs. (2022, September 26). Biogen Inc. Agrees to Pay \$900 Million to Settle Allegations Related to Improper Physician Payments. <https://www.justice.gov/opa/pr/biogen-inc-agrees-pay-900-million-settle-allegations-related-improper-physician-payments>
- Office of Public Affairs. (2021, July 21). EEG Testing and Private Investment Companies Pay \$15.3 Million to Resolve Kickback and False Billing Allegations. <https://www.justice.gov/opa/pr/eeg-testing-and-private-investment-companies-pay-153-million-resolve-kickback-and-false>
- Office of Public Affairs. (2022, July 7). West Virginia Hospital to Pay \$1.5 Million to Settle Allegations Concerning Impermissible Financial Relationships with Referring Physicians. <https://www.justice.gov/opa/pr/west-virginia-hospital-pay-15-million-settle-allegations-concerning-impermissible-financial>
- Pollitz, K. (2021, December 10). No Surprises Act Implementation: What to Expect in 2022. KFF. <https://www.kff.org/health-reform/issue-brief/no-surprises-act-implementation-what-to-expect-in-2022/>
- Reeves, K. (2022, July 14). Times Are Tight: Staff Shortages Prompt New Strategies. Applied Radiology. <https://appliedradiology.com/articles/times-are-tight-staff-shortages-prompt-new-strategies>
- Seshamani, M. and Lazio, J. W. (2023, March 3). NOTE TO: Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and Other Interested Parties. Centers for Medicare and Medicaid Services. <https://www.cms.gov/files/document/2024-advance-notice-pdf.pdf>
- Shaver, J. (2022). The State of Telehealth Before and After the COVID-19 Pandemic. Primary care, 49(4), 517-530. <https://doi.org/10.1016/j.pop.2022.04.002>
- The Physicians Foundation. (July 2022). 2022 Survey of America's Physicians. <https://physiciansfoundation.org/wp-content/uploads/2022/09/2022-Survey-of-Americas-Physicians-Part-2-of-3-Understanding-the-State-of-Physicians-Wellbeing-and-Assessing-Solutions-to-Address-It.pdf>
- The Physicians Foundation. (October 2022). 2022 Survey of America's Physicians. https://physiciansfoundation.org/wp-content/uploads/2022/11/PF22_Brochure-Report_Americas-Physicians-Part-3_V2b.pdf

References

- United States Attorney's Office. (2022, February 9). Catholic Medical Center Agrees to Pay \$3.8 Million to Resolve Kickback-Related False Claims Act Allegations. <https://www.justice.gov/usao-nh/pr/catholic-medical-center-agrees-pay-38-million-resolve-kickback-related-false-claims-act>
- United States Attorney's Office. (2022, November 10). Physician and Medical Office to Pay Over \$2.6 Million to Settle False Claims Act and Kickback Allegations. <https://www.justice.gov/usao-ct/pr/physician-and-medical-office-pay-over-26-million-settle-false-claims-act-and-kickback>
- United States Attorney's Office. (2022, June 10). Steward Health Care System Agrees to Pay \$4.7 Million to Resolve Allegations of False Claims Act Violations. <https://www.justice.gov/usao-ma/pr/steward-health-care-system-agrees-pay-47-million-resolve-allegations-false-claims-act>
- U.S. Centers for Medicare & Medicaid Services. (2021). Qualifying Payment Amount Calculation Methodology. <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/CAAQualifying-Payment-Amount-Calculation-Methodology.pdf>
- U.S. Centers for Medicare & Medicaid Services. (2023, June 14). Surprise billing & protecting consumers. <https://www.cms.gov/nosurprises/ending-surprise-medical-bills#:~:text=In%20many%20cases%2C%20the%20out,is%20called%20a%20surprise%20bill>
- U.S. Department of Justice Criminal Division. (2023). Evaluation of Corporate Compliance Programs. <https://www.justice.gov/criminal-fraud/page/file/937501/download>
- Weigel, G., Ramaswamy, A., Sobel, L., Salganicoff, A., Cubanski, J., and Freed, M. (2020, May 11). Opportunities and Barriers for Telemedicine in the U.S.. During the COVID-19 Emergency and Beyond. KFF. www.kff.org/womens-health-policy/issue-brief/opportunities-and-barriers-for-telemedicine-in-the-u-s-during-the-covid-19-emergency-and-beyond/

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