Physician Alignment Tips & Trends

PATT 2021

BI-ANNUAL REPORT

VMG HEALTH

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 2021 PATT report provides timely insight into the latest trends and regulatory changes that impact

physician alignment.

Physician Alignment: Tips & Trends

The past two years have reflected many of the same healthcare trends we outlined in VMG Health's 2019 PATT Report, such as a strong movement towards value-based care and an influx of private equity participants. Now, we also have the impact of the Coronavirus pandemic (COVID-19) and monumental changes to Medicare's Physician Fee Schedule. As a result, healthcare executives have been pressed to closely examine the goals and financial outcomes of their arrangements with physicians.

As the leader in healthcare valuation and strategy since 1995, VMG Health is involved with over 3,000 healthcare engagements annually ranging from joint venture development to compensation design. For any one physician arrangement, VMG Health may work with representatives from strategy, finance, compliance, legal, human resources, and/or operations. This in-depth insight has resulted in VMG Health being part of countless successful physician alignment strategies.

Health System Challenges & Strategies

Physician Insight & Trends

The Latest in Regulatory Guidelines

Health System Challenges & Strategies

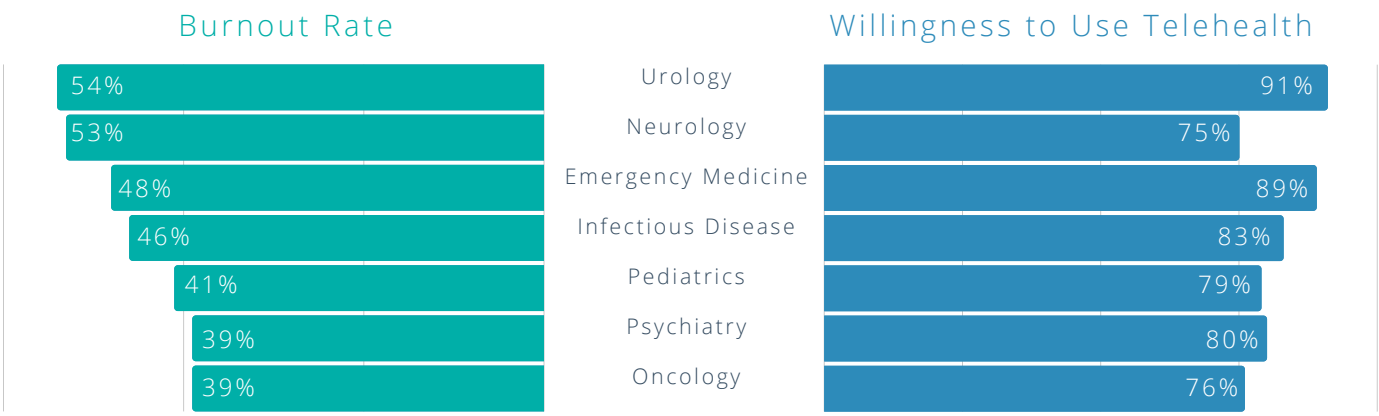
Today's healthcare landscape has more challenges and volatility than ever before. The focus on coordinated care to help lower costs puts health systems at the epicenter of this challenge, and physicians are the most important resource for success. Meanwhile, physician burnout remains high and private equity players may provide attractive options for physicians to dis-engage from their health system partner. The good news is that there are ways to improve physician alignment and financial performance with careful strategic planning, and the use of progressive technology such as telehealth.

Using Telehealth to Improve Physician Performance & Lower Burnout

For the last few decades, telehealth has been the emerging mode of care that gradually has gained acceptance across the healthcare industry. However, within the last year, telehealth utilization has skyrocketed as health systems have rushed to find a more cost effective, expedient, and safe means of providing access to care. The obvious catalyst in early 2020 was the increased need to limit in-person interaction due to COVID-19. Based on a study conducted by the Department of Health and Human Services, the percentage of Medicare primary care visits provided via telehealth increased from 0.1% to 43.5% between February and April of 2020. As its adoption continues to expand, the advantages which can accompany telehealth offerings have become increasingly apparent to health systems. Specifically, in a time of enhanced turbulence, telemedicine has proven effective in its ability to improve both performance and happiness within the provider force.

Physician burnout and provider shortages continue to plague the healthcare industry. The largest concerns on the minds of physicians, according to Medscape National Physician Burnout & Suicide Report 2021, are related to work-life balance and matters of compensation. Telehealth can be a helpful tool for health systems in addressing these concerns. From a compensation perspective, providers leveraging technology can extend care offerings uninhibited by geography, vastly expanding a provider's potential client base. Virtual visits have also been associated with lower rates of missed appointments, making more efficient use of a provider's clinical time. Further, the average time per visit is much lower for telehealth consultations as opposed to in person appointments, expanding a provider's consult capacity. Additionally, much headway

has been made at the legislative level with regards to licensure requirements and telehealth reimbursement, with the expectation that this trend will continue. In addressing work-life balance matters, telemedicine presents the unique opportunity to extend care from a home office or other non-traditional setting, providing increased flexibility in a medical professional's schedule. It is no coincidence, providers practicing in high burnout specialties are some of the most willing to try telehealth, according to physician surveys from Amwell, as shown below.



Further, patients receiving care through virtual means have responded with high satisfaction scores, indicating that efficiencies can be achieved without sacrificing service quality. Telehealth services obtained one of the highest overall customer satisfaction scores out of all healthcare, insurance and financial services industry studies in the 2020 JD Power Satisfaction Survey. According to the Telehealth Impact Study performed by the COVID-19 Healthcare Coalition, 83% of respondents who had at least one telehealth encounter between March 1, 2020 and January 30, 2021 felt that the overall quality of their telemedicine visit was good and 73% of users plan to use telehealth services again in the future. The industry recognizes that the quality of care need not be sacrificed in order to harness the benefits of telemedicine. In addition, even more simple telehealth services seem to have full support by CMS. In September of 2021, Psychiatric News reports, "The federal government is proposing to permanently allow payment under the Medicare program for 'audio-only' telehealth mental health services," which are to be part of the recommended changes to the 2022 Medicare Physician Fee Schedule.

All health systems, but specifically those experiencing provider burnout, should seriously consider the advantages that can accompany telehealth. VMG Health has extensive experience related to telehealth initiatives, including fair market value opinions for provider compensation, guidance on proper coding protocols, and strategic transaction support.

Handling the 2021 Medicare Physician Fee Schedule Changes

The 2021 CMS Physician Fee Schedule Final Rule (2021 MPFS) not only permanently expanded some of the temporary tele-health measures, but also reset the work relative value units (WRVU) and conversion factor to more accurately reflect the time and work effort dedicated by providers in office/outpatient settings. As a result, health systems are faced with forecasting the financial impact on existing contractual arrangements, predicting if other payors will follow suit, and making decisions on how to approach go-forward physician compensation arrangements.

The average organization will experience a

10% increase

in total provider compensation spend in 2021 if adopting the 2021 Medicare Physician Fee Schedule with no adjustments.

The changes represent a material change for providers of virtually every specialty, with the greatest impact expected in primary care due to the changes to the evaluation and management (E&M) codes, the office-based CPT codes used most often by physicians in primary care and other cognitive-based specialties. The WRVU values for new patient visits increased by about 9% on average, and the WRVU values for established patient visits increased by a staggering 32%. Since these codes amount to roughly 40% of all patient charges under 2021 MPFS, the impact to total physician WRVU levels is sizeable.

For more detailed information, the following article provides a review of these changes and estimated impacts on WRVUs and Medicare reimbursement for select physician practices specialties.

The Impact of the 2021 Medicare Physician Fee Schedule on Physician Practice Revenue and Provider Compensation

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Obviously, these changes will have an impact on both reimbursement and existing compensation models utilizing WRVUs as a basis for payment. The following provides considerations for forecasting the financial impact.

Projecting Physician Practice Revenue

While the 2021 MPFS provides data needed to help forecast how certain practices may be impacted by the reimbursement changes, healthcare organizations have also begun to consider how the changes impact commercial contracts since many utilize Medicare as the basis for their fee schedule(s). VMG encourages a review of all current contracts and an understanding of the items below to help accurately project the revenue impact:

1. Which CPT Codes are most frequently billed and how are those codes changing?
2. What is the base fee schedule that commercial payor contracts utilize? Is it a Medicare or a Market Fee Schedule?
3. If the answer to question 2 is Medicare, do the payor contracts specify a certain Medicare fee schedule or rely on the 'Current Year Medicare'?
4. Based on your payor contract terms, are you able to renegotiate commercial contracts?

To add complexity to the forecasts, organizations are recognizing another variable in the revenue equation: changes in coding. Prior to 2021, many organizations simply projected revenue impacts based on the physician fee schedule changes. Now, under the 2021 MPFS, there are also significant coding adjustments for office/outpatient codes which were made related to medical decision making, documentation, and time requirements which are further detailed in the subsequent section "Top Coding Concerns with Physicians".

Therefore, to properly prepare forecasts, healthcare leaders should consider payor mix, commercial contracts, the 2021 MPFS changes, and coding updates. With all the changes in reimbursement along with the movement of hospital-based physicians aligning more closely with hospitals, VMG Health believes this is an opportune time to reassess and carefully renegotiate commercial payor contracts.

Considerations for Provider Employment Agreements

Since most organizations compensate contracted and employed physicians, at least in part, based on the number of WRVUs they generate, physician compensation under contractual arrangements is likely to be impacted. In fact, if the 2021 MPFS updates are implemented without any adjustments, VMG estimates the average organization would experience a 10% increase in total provider compensation spend in 2021 for the same level of work effort and revenue as in 2020.

There are numerous ways organizations are handling this change, and many are still contemplating the best solution. Based on VMG Health's insight, numerous organizations chose not to implement the new WRVU fee schedule in physician compensation models due to the challenges presented by COVID-19 and material expected impact of the changes. Therefore, many physicians are still being paid based on 2020 WRVUs and conversion factors. For many, this decision alleviated the concerns of business leaders related to fair market value and commercial reasonableness, while also maintaining budget neutrality during a tumultuous period. Similarly, some clients are applying by specialty adjustments to the new conversion factors based on internal analyses for financial sustainability.

Meanwhile, some organizations recognized the intention of the 2021 MPFS and implemented a bigger compensation lift to primary care and cognitive specialties than to surgical and hospital-based specialties. Others held every specialty constant and provided an equal inflationary lift to physicians in all specialties. Regardless of which approach an organization takes to 2021 and 2022 provider compensation, many are using the interim period as an opportunity to reevaluate and redesign their compensation plans to move away from WRVUs and toward models that more greatly reward physicians for quality, patient experience, access, and other performance-based metrics than for just WRVU productivity.

As a result of the 2021 MPFS changes, hospitals and health systems have numerous considerations when negotiating both payor contracts and physician compensation agreements in the upcoming year. VMG Health has been assisting clients forecast these impacts and design progressive compensation models to prepare for these significant changes. VMG Health has also been involved with negotiating better reimbursement with commercial payors as part of the solution. Negotiating with payors and physicians is a complex and important initiative which can have a material impact on your bottom-line.

Understanding the Private Equity Play

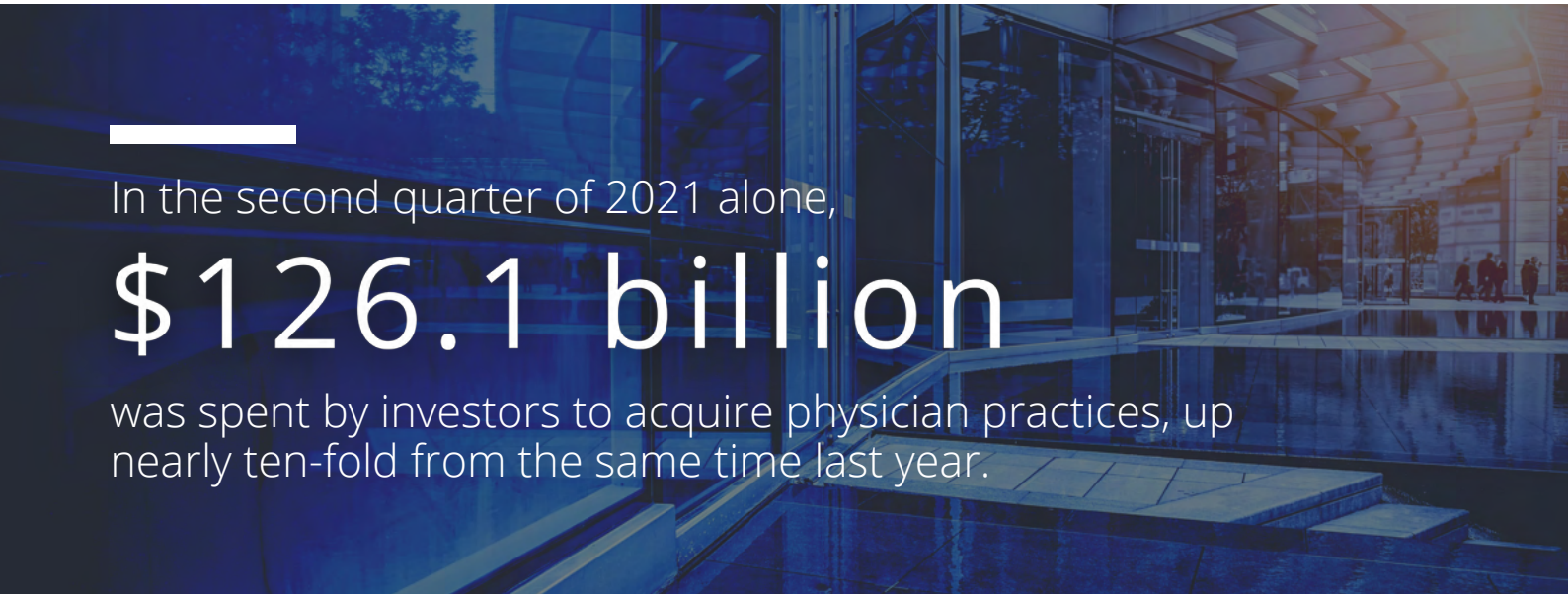
As if designing new physician compensation models wasn't complex enough for physician alignment planning, the market for physicians has seen a spike in interest from new market participants, including private equity firms. In the past three years, private equity ("PE") firms have increased investment activity in the healthcare industry. PE firms have targeted the provider market due to the fragmented nature of physicians, opportunities for consolidation, and benefits of scale related to back-office duties, plus the increasing need for technology investment.

From 2019 and 2020, it was reported that corporate entities, such as PE, acquired 17,700 physician practices. In the second quarter of 2021 alone, $126.1 billion was spent by investors to acquire physician practices. Solic Capital Management reported that today's investors are mostly private equity firms and special acquisition companies, as opposed to the health system buyers from five years ago. One potential cause for the increase in transactions and spending is due to the variety of specialties now being acquired. For several years, VMG observed acquisitions primarily in the areas of anesthesiology, dermatology, and gastroenterology. While these specialties are still ripe for acquisitions, PE is shifting focus to other specialties such as primary care, orthopedics, and urgent care.

So, what are the advantages for physicians to want to sell to PE? One of the primary benefits to these acquisitions is that physicians sell a portion of their future compensation for an upfront amount, carrying large multiples. Physicians also receive "roll-over" equity for future compensation upside. Furthermore, for physicians desiring to retain their autonomy, PE acquisitions allow for a higher level of physician control and governance while still benefiting from larger scalability and infrastructure investment.

Due to the nature of a healthcare system, the strategy and benefits that can be offered to a physician will be different. As an example, where most PE acquisitions focus on a single specialty or a few related specialties, health systems can provide clinical integration across a spectrum of specialties. This can be intrinsically rewarding to physicians, as it often results in higher quality outcomes for patients within a connected continuum of care. Lastly, PE firms usually have a desired timeline of five years between transactions, while health systems, through employment agreements, have much longer terms and therefore stability.

Ultimately, the value proposition offered by a health system continues to be stable, effort-driven compensation, the ability to focus on patient care rather than a business, and protection against rising costs



and declining reimbursements. In contrast, although private equity often requires a short-term reduction in compensation, it offers physicians the opportunity to participate in long-term business growth. While it is unclear just how successful private equity investments in medical groups will be, it is important for health systems to understand the differences in transaction terms so they can effectively communicate the value proposition they offer when competing for medical groups. As PE healthcare investment activity continues to grow, health systems will be pushed to be more creative to remain competitive. VMG Health has seen this take place as health systems are already integrating innovative and competitive compensation model changes to incentivize physicians in new ways.

Tackling Medical Group Optimization

More health systems are taking a multi-faceted approach to maximizing medical group performance. The exponential growth in physician and advanced practice provider employment and the growth in reimbursement tied to cost, quality and access have heightened the importance of medical group strategy. However, many organizations are continuing to experience underperformance across several domains (cost, growth, access, etc.), and attempts to improve performance have stalled or been met with significant resistance. In most cases the definition of performance is too narrow to identify the actionable strategies necessary for improvement.

Measurement of medical group performance and provider efficiency has historically been based on investment or operating loss per physician. In VMG Health's experience questions pertaining to medical group optimization are complicated and require consideration of several indicators. Commonly used measures like investment per physician and provider FTE are helpful but can be misconstrued without proper context due to a myriad of factors including but not limited to medical group composition, medical group structure, care model, payor contracting strategy, overhead allocation and payor mix.

To truly understand medical group performance, it should be evaluated across a series of clinical, financial, operating and community domains to assure the value of the group is fully realized (and understood). Focusing on only one or two aspects of medical group activity can result in an overly narrow and often inaccurate assessment of medical group value. The approach to assessing economic sustainability/affordability of a medical group should be based on a complete picture of the medical group's impact on health system financial performance and not be limited to a review of practice operations.

It is critically important to consider how the medical group functions, performs and contributes to the health system in several areas including: 1) growth trajectory and overall affordability, 2) engagement of the provider group, 3) data availability and reporting, 4) provider care model and compensation, and 5) provider governance. Strong performance across one or two domains is not indicative of sustainability, and category weighting is required to acknowledge the relative importance each.

Each of the aforementioned domains can be evaluated across several factors that when indexed essentially score the medical group's overall health and determine whether or not financial, strategic, and clinical alignment requires modification for sustainability.

Performance Domains

> Affordability

The affordability domain evaluates the extent to which the magnitude of the hospital or health system's investment in the medical group is appropriate given the size, operating performance, structure, and breadth of the medical group. The domain also considers whether the investment is financially sustainable for the organization when tested against the parent organization's size, operating performance and market conditions.

> Engagement

The degree to which medical group infrastructure and polices support physician to physician and physician to group accountability. The engagement domain evaluates whether polices support the individual or the collective, to what extent the governance structures create peer accountability, and a set of medical group values that align with health system goals and objectives.

> Data Reporting

The ability of the health system and the medical group to track, report (internally and externally) and act on data is essential. Supportive data systems, with actionable dashboards and reports for providers, are increasingly being deployed to maximize utility of the group practice. Medical groups lacking effective data tracking, reporting and management capabilities are extremely limited.

> Care Model

Patient care is increasingly being provided in non-traditional settings and by care teams versus individual providers. What policies, procedures and models have been developed and implemented that support care innovation, efficiency and patient access? How well developed are virtual protocols and how mature is the medical group's thinking about advanced practice provider utilization and deployment? Does this translate into aligned remunerations systems for providers?

> Governance

The governance domain assesses how decisions pertaining to medical group management and operations are made as well as who is making the decision. There is not a one size fits all approach to organizational structure and decision making. What structures and policies support provider led management and decision making? To what degree have service line management and medical group operations been integrated to assure efficient and effective operations.

The COVID-19 pandemic has impacted hospital and health system margins, forever changed care models through technology, and impacted how consumers expect access. As a result, the domain of affordability is being assessed by leading health systems across the country.

In VMG Health's experience, questioning medical group affordability is both essential and complicated. Many organizations struggle with assessing current performance in a way that provides a comprehensive view and provides actionable strategies for improvement. It is critical this work effort is organized in the right way as a simple benchmark exercise is largely ineffective in driving change.

VMG Key Take-Aways:

Health Systems Challenges & Strategies

Health systems must understand telehealth opportunities and create a thoughtful strategy around the numerous impacts of the 2021 MPFS changes. That said, being able to optimize medical group performance may be the most important strategy of all. VMG Health has a deep understanding of telehealth reimbursement, the physician fee schedule changes and private equity strategies to help healthcare organizations stay informed about the physician market. Further, VMG Health can help maximize medical group performance with a systematic and custom approach.

Physician Insight & Trends

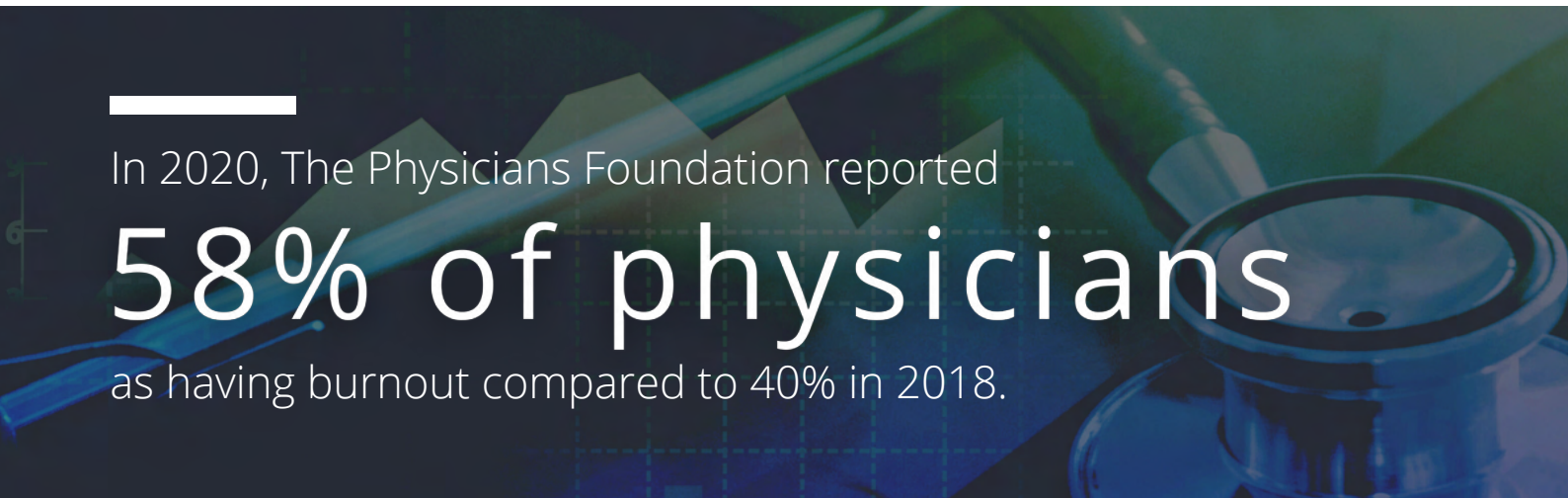
One of the best ways to devise a strategy around physician alignment, is to understand things from a physician's viewpoint, and address top concerns. Further, seeking insight into supply & demand trends and the latest in compensation models is essential. Perhaps the most important part is frequent communication with your physician partners in order to successfully execute your physician alignment strategy.

Addressing Physician Concerns

In the 2019 PATT Report, VMG provided insight on three of the top physician concerns of morale, burnout, and technology woes. Since the last report, the current events of the COVID-19 pandemic have unfortunately exacerbated some of these issues. For many physicians, the pandemic has also brought about some unforeseen and beneficials changes, most notable, the advancement of IT and telehealth. In fact, a Deloitte study indicated that physicians believed that AI technologies that assisted with more day-to-day clinical workflow had the potential to "save significant time and resources, while 49% said they could increase job satisfaction."

After stay-at-home orders were put in place in the spring of 2020, a monumental shift from in-person to virtual care took place in the U.S. Phone and video consultations went from approximately 20% of all visits to over 80%, and almost overnight, virtual care was available to a wide swath of the U.S. population. Aside from virtual care, though, the pandemic has brought an overall increase in usage of technology in the healthcare industry. In an EY survey, 83% of physicians stated they are more comfortable utilizing technology than before the pandemic. The EY survey also found that increased adoption of technology by a physician increased their desire for future technology. Healthcare technology companies have the potential for a large growth in demand and need for their services, so it'll be important that their innovations and products focus on improving usability while minimizing workflow disruptions for physicians. Physicians, though, already appear to be hopeful that these innovations will improve their daily workflow. In a Deloitte survey, 41% of physicians stated that they believe other technologies such as cloud computing, predictive analytics, automation, AI, data sharing/interoperability, and 5G/better connectivity will impact traditional delivery of care.

In addition to increased demand for healthcare technology being able to drive improvements for physicians, we've also seen in the past year the ability for regulatory bodies to adapt to changing methods of providing



care. The Centers for Medicare and Medicaid Services (CMS) spurred on demand for virtual care during the pandemic by expanding reimbursement for telemedicine services. This action increased physicians' access to patients, and physicians reported that without this, they would not have been able to reach as many patients during the pandemic. In addition, CMS also provided administrative relief to physicians during the pandemic by accepting verbal orders rather than only written EHR orders and easing licensure requirements for physicians providing virtual care across state lines. These targeted policy changes that keep physician concerns in delivering care as a main focus open up another avenue for the industry to potentially lower the administrative burdens and stresses faced by physicians.

> While the implementation of technology and smart policy decisions during the pandemic have shown some potential to provide relief on these top physician concerns, in general physicians believe "dissatisfaction, disengagement, and burnout" have been compounded by the pandemic. In 2018, The Physicians Foundation reported 40% of physicians as having burnout compared to 58% in 2020. In a separate March 2021 study by the National Institute for Health Care Management (NIHCM), it was indicated that the top reason for burnout was moral injury. In addition, the NIHCM study also indicated that 69% of physicians reported colloquial depressions and 20% reported clinical depression6. While these issues were being faced by physicians long before the COVID-19 pandemic, the pandemic has opened up a national conversation about mental health and wellbeing, especially in regard to health care providers. This spotlight has created a new environment of questioning the status quo on the wellbeing of our health care providers and how to provide them the tools to be successful at the job of delivering care.

This changing perspective has many healthcare systems moving to novel solutions to combat these issues. One new approach that is gaining steam is the establishment of employee wellness programs, led by a specialist and expert in addressing healthcare professionals' well-being – a chief wellness officer. Per HealthAffairs.org, this executive level position "establishes well-being on a level of importance equal to that of quality, informatics, and data in the sustainability and success of an organization." Specific to the pandemic, the New England Journal of Medicine notes that a chief wellness officer can directly combat physician burnout by "identifying sources of worker anxiety, deploying support resources, and participating in operational decision-making, and assessing the impact of fluid pandemic protocols on clinician well-being." The opportunity for health care organizations now is considering whether the introduction of a wellness program, or appointing a chief wellness officer, can help to reduce physician burnout, increase engagement, and generate cost savings associated with burnout.

Finally, in addition to wellness programs, many health systems continue to invest in leadership roles for physicians. Physicians in leadership positions can offer input and pre-emptively address issues before they arise in the daily work of clinician providers. MGMA reported that 77% of healthcare leaders use a dyadic team model, where authority is shared between an administrator and a physician. This dyadic model has shown the potential to improve patient care and reduce physician burnout by facilitating collaboration and encouraging engagement. A potential crossover exists to push physician leaders to collaborate with newly established wellness programs or wellness executives as a strategy to focus and align the values of an organization in regard to physician wellness, burnout, and engagement and establish multiple champions of this initiative within the organization.

While the pandemic has brought so many challenges to our everyday lives, it has opened up new perspectives on long standing problems. New perspectives may be the right path to target these physician issues and struggles that have been so longstanding. VMG Health has insight to what works in addressing today's top physician concerns based on decades of experience and a keen understanding of the most recent challenges.

Physician Supply & Demand Trends

Due to COVID-19, advances in technology over the recent years, and the aging population, VMG Health has seen strong activity in several specialties. This year it is difficult to illustrate recent trends in compensation due to the COVID-19 challenges with the survey data.

However, VMG Health has published the following article, which provides some interesting insight on compensation trends. Regardless of statistics, hospital leaders should consider focusing recruitment efforts on the following specialties.

Key Takeaways from the Medscape Physician Compensation Report 2021

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Neurology

specialties are in high demand due to the desire for hospitals to achieve a stroke center designation, and the profit potential for neurological services.

Psychiatry

The COVID-19 pandemic contributed significantly to the already shifting landscape that was the treatment of mental health. Recent strides in the diagnosing of mental illness have allowed psychiatrists to diagnose patients sooner which allows the patient to receive earlier treatment which can allow the prescribed treatments to be more effective. This trend of early diagnosis, along with the impact of COVID-19 on the shifting public perception of mental health has allowed for far more patients to seek mental health care than ever before. Additionally, the pandemic has ushered in the use telemedicine services that allow patients to receive the care they require without stepping foot outside their homes. Many patients are also now able to have mental health care covered by their insurance. According to the U.S. Department of Health and Human Services, by 2025, the psychiatrist shortage could be as high as 6,090 psychiatrists, or 12%. The challenge for hospitals and health systems to gain access to this growing pool of patients will be competitively recruiting as the supply dwindles, along with increased competition from telemedicine companies

Rheumatology

Much like the psychiatry trends of utilizing telemedicine to better serve patients over the course of the COVID-19 there has been a drastic shift in the treatment of rheumatological related services. The use of smartphone apps, telemedicine, and telemonitoring will likely reduce the need for outpatient visits to a rheumatologist. As the treatment for rheumatological conditions trends away from outpatient visits the importance of patient reported outcomes will become a crucial piece of the overall care to the patient. Additionally, the pandemic contributed to the acceleration of using AI to improve the efficacy and efficiency of analyzing medical images. All the technological advances that have been a response to COVID-19 has presented hospitals and health systems with an opportunity to greatly improve their efficiency in the care for rheumatological diseases. The efficiency of care for rheumatological diseases will be crucial as the shortage of rheumatology physicians is expected to become significant in the coming years. Based on the Workforce Study by the American College of Rheumatology, it is projected that by 2030 adult rheumatology providers will decline by 25% since 2015 in terms of full time-equivalents. This decrease in supply will result in the demand for rheumatology providers exceeding the supply by 102% in terms of full time-equivalents.

CT Surgery/Cardiovascular Sub-Specialties:

According to the CDC, about 655,000 Americans die each year from heart disease complications. The prevalence of heart disease is only expected to increase over the course of the next 30 years and health leaders are tasked with ensuring adequate staffing in the cardiovascular specialties to take care of patients at the rates needed. Specifically, VMG Health has seen an increased focus on cardiothoracic surgery as fellowship spots are exceedingly limited in this specialty and hospitals are competing to recruit these highly specialized physicians. In addition, according to an article published on the AHA Journals website, “the demand for cardiothoracic surgeons could increase by 46% on the basis of population growth and aging if current healthcare use and daily service delivery patterns continue” by the year 2025. Technological advances in cardiothoracic surgery are allowing heart specialists to perform more surgeries in a less invasive manners. In addition, we note that the set of services provided under the specialty of cardiothoracic surgery have broadened. Lastly, we have observed favorable reimbursement for certain operative procedures such as Transcatheter Aortic Valve Replacement (TAVR), making this a potentially lucrative investment for health systems.

Neurology

America’s aging population is soon going to need increased health care related to neurologic diseases. A study done by the American Academy of Neurology (AAN) found that the demand for neurologists is expected to grow faster than the supply. The study found that by 2025, the supply of neurologists will be approximately 18,060 while the demand for neurologists will be approximately 21,440. Additionally, according to a report from the AAN there is a mismatch between the need for neurologists and the availability of neurologists in nearly every U.S. state. Reasons for this high demand include the desire for hospitals to achieve a stroke center designation, as well as the fact that this can be a highly profitability service line. To further substantiate this trend, VMG Health has seen an increase in requests for valuation opinions and consulting associated with many neurological specialties, including neuro-hospitalists, neuro-intensivists, neurology-stroke and neuro-interventional (endovascular).

Neurology-Interventional (Endovascular)

VMG Health has seen an increased concentration on neuro-interventional endovascular surgery as a specialty with clients over the past few years as new techniques in this field of medicine have become the most effective means for treating stroke, vascular, and spinal cord medical conditions in a growing number of patients.

The training for this field is intensive with a focus on cardiology, vascular surgery, neurology, and radiology. As such, there is a shortage of physicians specialized in this field to meet the growing demand. According to an article published on Spine Universe.com, there were only 500 neuro-interventional surgeons in the United States making it one of the rarest and most specialized surgical specialties. Neuro endovascular surgery is not yet widely reported in nationally published physician compensation and productivity survey data, making it difficult for health systems to competitively recruit for this specialty as there is not yet a set baseline for compensating physicians for this type of specialization. As a result, VMG Health has seen an increase in fair market value opinion requests for this specialty.

Understanding the shift in specialty focus will enable health systems to adapt with the times to better serve the patient populace. A proactive effort to recruit in the specialties outlined in the previous sections will prove to be advantageous for health systems as VMG Health expects to see these specialties continue to grow in importance over the years to come. It will also become increasingly important for health systems to fully develop their telehealth-based service lines as remote health care services are here to stay regardless of COVID-19. All that said, perhaps the most important physician specialty to develop a strategy around for the upcoming year is primary care.

Primary Care's New Major Role

Currently, the United States has a fragmented system where patients are required to visit multiple specialists for each ailment. In fact, the "average Medicare patient saw two primary care providers and five specialists a year." Even more shocking, it was not uncommon that "patients with multiple chronic conditions could see up to 16 physicians a year."1 While this sophistication allows for greater advancement in subspecialty care, this fragmentation makes it difficult, and potentially more expensive, for each provider to deliver the necessary patient care. As a result, governmental and commercial payors have been focused on primary care providers, the "gate keepers". Maximizing the health and safety of the American healthcare system requires the coordination of patient care by provider teams, which begins in the primary care setting and can lead to real cost savings and reductions in admissions, readmissions, and emergency department visits.

Unfortunately, recent estimates from The Complexities of Physician Supply and Demand: Projections from 2019 to 2034 indicate a shortfall of approximately 17,800 – 48,000 primary care physicians by 2034. The shortage not only impacts patient access to care, but more specifically, preventative care and care coordination in an increasingly aging patient population. In order to combat the impending shortage and

recognize the role of primary care in overall population health, the Centers for Medicare and Medicaid Services ("CMS") has implemented a number of changes to the reimbursement models for patient services. Most notable is the updates to the 2021 Medicare Physician Fee Schedule which had a significant impact on primary care reimbursement.

As an example, there were material revisions to a subset of E&M codes (99201-99215) related to office/outpatient visits to assign higher values to recognize the effort involved in care coordination and other non-face-to-face services provided by practitioners. The changes were intended to more accurately reflect the time and work effort dedicated by providers based on guidance and input from the American Medical Association ("AMA"). In addition to the E&M codes, CMS also revised codes that are similar to E&M visits, or those that include E&M visits as part of the services bundled within the code. These codes include transitional care management (99495 and 99496), cognitive impairment assessment and care planning (99483), a subset of end-stage renal disease services (90951-90970), and annual wellness visits and initial preventative physical exams (G0402, G0438, G0439), all prominently billed by primary care providers.

Given that approximately 40% of all MPFS allowable charges are E&M visits, these changes are expected to have the greatest impact on primary care. Depending on an individual physician's payor mix, the 2021 MPFS could result in an increase in reimbursement of up to 7.0%. These changes are a clear sign that primary care is expected to have a new major role in the future of healthcare.

Advanced Payment Models: Direct Contracting Model

Consistent with the value-based care models that CMS has implemented over the last decade, Direct Contracting ("DC") is a relatively new opportunity for healthcare organizations to engage in a risk-sharing arrangement to reduce cost, while maintaining or even improving quality of care and patient outcomes. DC creates three payment model options that are expected to appeal to a broad range of healthcare organizations due to the reduced administrative burden, focus on beneficiaries with complex, chronic conditions, and the inclusion of organizations that have not typically participated in other innovative care models.

Within DC, CMS introduced the Primary Care First ("PCF") model that is limited to supporting the delivery of high quality, advanced primary care. The PCF model is structured to increase and improve access to care coordination, patient and caregiver engagement, and planned care/population health. The payment model includes a simple payment structure that is comprised of three payment types:

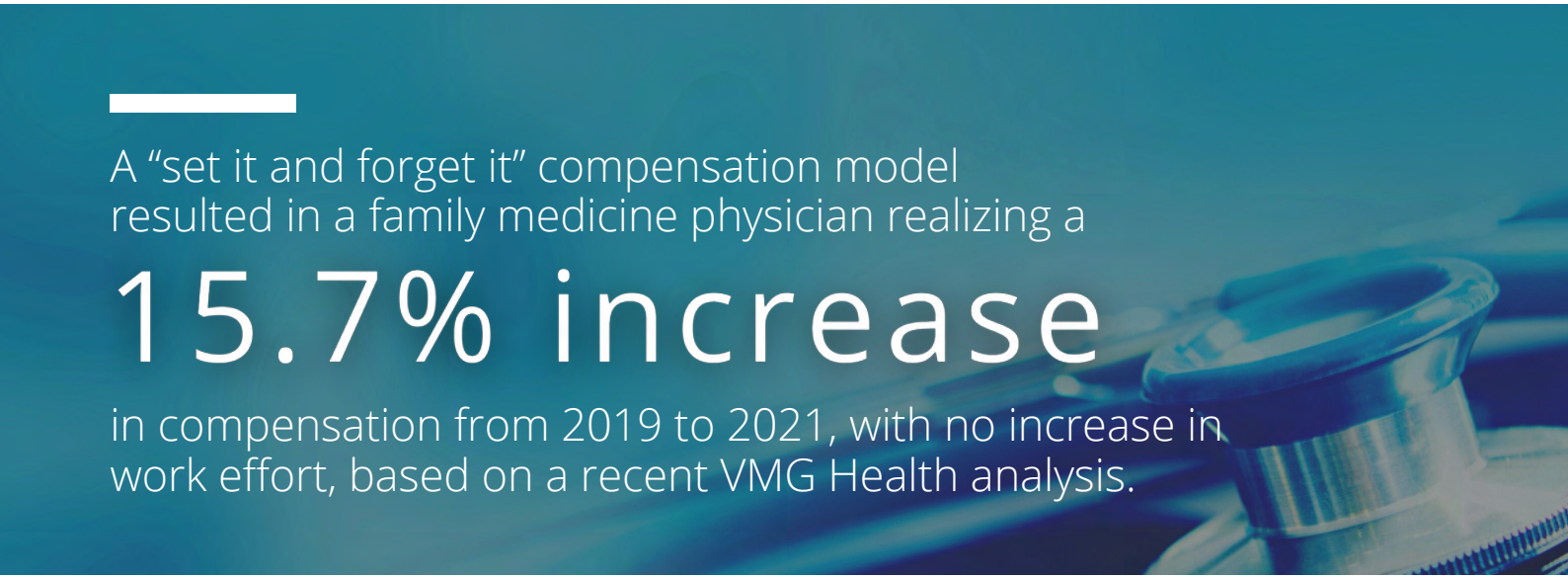
- A risk-adjusted prospective population-based payment
- Flat fee per visit per beneficiary for in-person treatment and care
- Performance-based adjustment based on outcomes with up to 50% upside and up to 10% down-side risk based on one of two outcome measures: acute hospital utilization or total cost of care.
- Only practices achieving certain predetermined clinical quality and experience outcomes will be eligible for the positive performance-based adjustment.

Primary care payment models from both payors and employers are evolving at a rapid rate with a significant focus on savings and quality through care coordination. In order to maximize reimbursement from payors, hospitals and health systems should align incentives in their payor contracts with their physician

arrangements. This strategy will be critical in the upcoming year, requiring new compensation models and robust communication with primary care providers.

Compensation Model Design in 2021

With so many changes happening all at the same time, one of the biggest challenges facing organizations in 2021 and 2022 is designing a compensation program that is both directionally aligned with contemporary healthcare trends and compliant with changing federal fraud and abuse regulations. In addition to the significant 2021 MPFS changes, key issues for organizations to consider as they update physician compensation models in 2021 and 2022 include less reliable benchmark survey data and new updates to the Stark Law and Anti-Kickback Statute.



Benchmark Surveys Are Getting Less Reliable

Most organizations use industry salary and productivity surveys to set physician compensation levels. Many have a "set it and forget it" type of approach, with physician salaries and conversion factors automatically being re-based to reflect the median or some other target market percentile using the latest salary surveys. While this approach may have worked well to simplify compensation model design in previous years, challenges with the survey data over the next few years make this approach an unwise strategy for organizations heading into 2022. In an analysis of the most recent industry surveys, VMG found that a family medicine physician producing median WRVUs under a "set it and forget it" type of approach would realize a 15.7% increase in compensation from 2019 to 2021, with no increase in work effort.

The latest survey issues revolve around two major trends: COVID-19 and 2021 MPFS changes. First, the pandemic had a significant impact on the 2021 surveys, based on 2020 data. In analyzing the 2021 surveys, VMG noted stable levels of compensation, likely due to organizations providing compensation protections to physicians during the pandemic. However, VMG noted significant decreases to both WRVUs and professional collections, resulting in significant increases in the reported ratios of compensation per WRVU and compensation as a percentage of professional collections. While we see these ratios typically increase between 1 and 3 percentage points per year in a typical year, increases from 2020 to 2021 surveys were in the double digits for several subspecialty areas, increases which, if implemented, would result in a significantly increased provider compensation cost for the same work effort as in 2020.

Second, the 2022 surveys (based on 2021 data) will likely be impacted and perhaps significantly so by the changes to the 2021 MPFS. Some survey organizations will likely try to control for the 2021 MPFS changes, however, since data are self-reported by hospitals, health systems, physician-owned groups, and the like, it is highly likely the self-reported WRVUs (and resulting compensation per WRVU ratio) will reflect a mixture of both the 2020 and 2021 MPFS. Therefore, relying strictly on surveys to set compensation levels in 2021 and beyond may result in compensation that is misaligned with market.

More insight on this topic may be found in the following article.

Amid A Perfect Storm in Healthcare, A Cautioned Approach to Physician Compensation Surveys Is Warranted
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The first surveys that will show the impact of the 2021 MPFS are the 2022 surveys, which will be published in mid-2022. Many organizations are looking to implement the 2021 MPFS in 2022 despite the lack of comparable compensation and production data reflecting these changes. It is important for these organizations to adjust compensation models in a way that accounts for both expected changes in reimbursement and the intentionality of the CMS changes (i.e., to provide greater relative reimbursement to office-based specialties compared to proceduralists). From a reimbursement standpoint, organizations must further consider the effects of the temporary increase to rates provided in the Consolidated Appropriations Act of 2021, and the proposed 3.75% reduction to the conversion factor in 2022.

If an organization is to use the 2021 surveys (based on 2020 data) to set compensation, many considerations must be given to the expected impact of all these new factors. As such, the actual rates per WRVU utilized by an organization should account for:

1. The effect COVID had on productivity and compensation to productivity ratios
2. The increased WRVU values in the 2021 MPFS
3. The organization's projected changes in revenue in their 2022 payor contracts
4. Anticipated market movement in compensation for an individual specialty

Changing Fraud and Abuse Regulations

To cap off an era of change, new fraud and abuse regulations (the Stark Law and the Anti-Kickback Statute) took effect on January 19, 2021 that may fundamentally change how organizations approach compensation in 2021 and beyond. While there were many significant changes such as updated definitions of fair market value and commercial reasonableness and the separation of the "volume or value" standard from the definition of fair market value, the biggest change impacting compensation design is the addition of exemptions and safe harbors for value-based arrangements, which among other things, provide for greater upside compensation potential for physicians that take on higher levels of risk in their remuneration formula.

Organizations must obviously consult with both their internal and/or external counsel to determine whether they meet these new value-based exemptions and the rules they'll need to follow to satisfy the exemptions,

but presuming an organization comfortably meets all the legal requirements, compensation models that include a significant amount of compensation at-risk for performance related to value-based activities can result in higher levels of compensation for high-performing physicians that may not be subject to fair market value requirements. That said, VMG Health is seeing a spike in healthcare organizations adding value-based care components to their existing compensation arrangements with physicians, most of which do not put the physicians at risk. As a result, determining the fair market value for both quality and cost savings has been a major topic for healthcare executives.

For more on this topic, please see the following article.

Considerations for Determining Fair Market Value Physician Compensation Under Stark's Final Rules

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Considerations for Compensation Model Design in 2021 and 2022

Considering all the changes happening at once, many organizations are using the opportunity to rethink their provider compensation formulas to establish remuneration systems that reward physicians and advanced practice clinicians (APC) differently. Most notably, organizations are considering changes that more proportionally recognize primary care and other cognitive specialties, consistent with changes to the 2021 MPFS, and many are using the opportunity to place more emphasis on quality, patient experience, patient access, and other value-based metrics within the provider compensation structure and less on wRVU-based productivity. In addition, there has been an increase in the use of APCs which has its own fair market value implications.

Compensating Physicians for APC Supervision

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More on this topic, can be found here. There are countless ways to structure new compensation models, and consideration to the myriad of changes should all be considered prior to developing a long-term strategy.

Regardless of how your organization has tackled these changes to date, VMG recommends careful consideration of your compensation strategy going forward. Organizations that take the time to streamline models today to align with changes in reimbursement and where healthcare is headed will set themselves up for greater success tomorrow.

Further insight in provided in VMG Health's article linked here.

Survey Says: The Time to Evaluate Your Market-Based Physician Compensation Plan Designs is Now

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Of last note, it is particularly important to consider the potential long-term impacts of reimbursement since provider employment agreements and compensation models tend to be fixed for more than one year. As a result of all the changes in physician reimbursement, many health systems have already started updating forecasts, rethinking compensation model design initiatives, and preparing for payor renegotiations.

VMG Key Take-Aways:

Physician Insight & Trends

Thoroughly understanding the physician landscape is critical for successful alignment. Physician burnout remains a top concern. Fortunately, the telehealth movement is providing some relief to burnout and many physicians are embracing its benefits. With the aging population and focus on mental health, there will be a strong demand for numerous specialties, and a focus on the primary care setting to keep costs down and quality up. Lastly, based on the changes in Medicare reimbursement and the value-based care movement, physician compensation redesign will be a key component of a health system's success in the long-run.

The Latest in Regulatory Guidelines

The regulatory environment is a staple in every healthcare decision, and especially important when contracting with physicians. A growing area of complexity is compensating physicians consistent with fair market value. This is one area that is more complicated than obvious fraud and abuse schemes since it requires the application and understanding of valuation concepts.

Ambulatory Surgery Centers are in the Spotlight in the OIG Advisory Opinion NO. 21-02

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Physician Speaking Programs in The Crosshairs in OIG's Special Fraud Alert

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Just recently, the industry has seen the Office of Inspector General's (OIG) issue two new opinions related to the importance of having compliant arrangements with physicians that called out the fair market value requirement.

To further illustrate the importance of compliance with healthcare regulations this year, there has been a focus on individual accountability resulting in material monetary penalties for providers. At the same time, the Final Stark Law and Anti-Kickback Statute has signaled more flexibility with physician arrangements when aligned with CMS' value-based care movement. Lastly, it is worth noting that the intent and strength of an organization's compliance policy is heavily considered by regulatory authorities. Just recently, the Department of Justice (DOJ) signaled the importance of keeping your compliance program updated to demonstrate your organization is taking compliance seriously.

Final Stark Law and Anti-Kickback Statute Implications

On January 19, long-awaited adjustments to the Centers for Medicare and Medicaid Services' ("CMS") Physician Self-Referral Law (commonly referred to as the "Stark Law") and the Department of Health and

Human Services OIG Anti-Kickback Statute ("AKS") took effect that make it easier for hospitals and health systems to transition from volume to value-based care. As a result, VMG Health has seen a marked increase in questions around how to value quality and distribute shared savings to providers.

Fortunately, there are several themes around Stark's exceptions and the AKS' safe harbors that demonstrate what regulatory authorities consider acceptable as it relates to physician compensation associated with value-based arrangements. Further, it is comforting to see consistency from regulatory bodies as demonstrated by themes that are consistent with previous favorable gainsharing/shared savings arrangements opinions issued by the OIG. The following provides a summary of salient points to consider when establishing a physician compensation arrangement containing payments for value-based initiatives:

1. Value-based metrics need to be selected based on clinical evidence or credible medical support
2. Value-based payments for outcomes should be based on objective and measurable data
3. Payments for improvement in cost or quality should be rebased annually
4. Be cautious of compensation tied to maintenance goals
5. If the physician takes on downside-risk, it may support higher compensation
6. Include safeguards for quality in arrangements focused on cost savings

As it relates to the structure of agreements, the OIG has loosened the requirement for setting aggregate compensation in advance by requiring only that the "methodology" be set in advance. This allows for true outcomes-based payments. Arrangements can now be structured so that if a physician reaches superior performance for a quality metric contained in an agreement, he or she can earn a higher amount than if only a small improvement in quality was achieved.

In VMG Health's experience, many of the arrangements in which clients are needing a fair market value opinion are not associated with the new Value-Based Enterprise created by the Final Rules. Rather, healthcare leaders are requesting quality and shared savings compensation components be added to existing arrangements such as PSAs and employment agreements. There has also been a spike in requests for consulting associated with co-management arrangements and hospital efficiency incentive programs, both of which can be powerful ways to improve quality and lower costs at the hospital. Specifically, there has been more of a focus on these three questions:

1. What makes a quality metric contained in an arrangement valuable from a fair market value standpoint?
2. How much shared savings can I distribute to physicians that have assisted in generating those savings?
3. May we "stack" quality and shared savings compensation on top of existing fee for service models?

All of these questions should be addressed with a deep understanding of the intent under the value-based guidelines. If you create a physician alignment arrangement that aims to lower costs and improve quality, while maintaining compliance with the fair market value standard, you should be in the clear.

For further insight into how to look at these arrangements, there is additional information in the following article.

Three Questions to Consider Before Distributing Value-Based Payments to Physicians

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Quality Metrics & FMV: By Specialty Considerations

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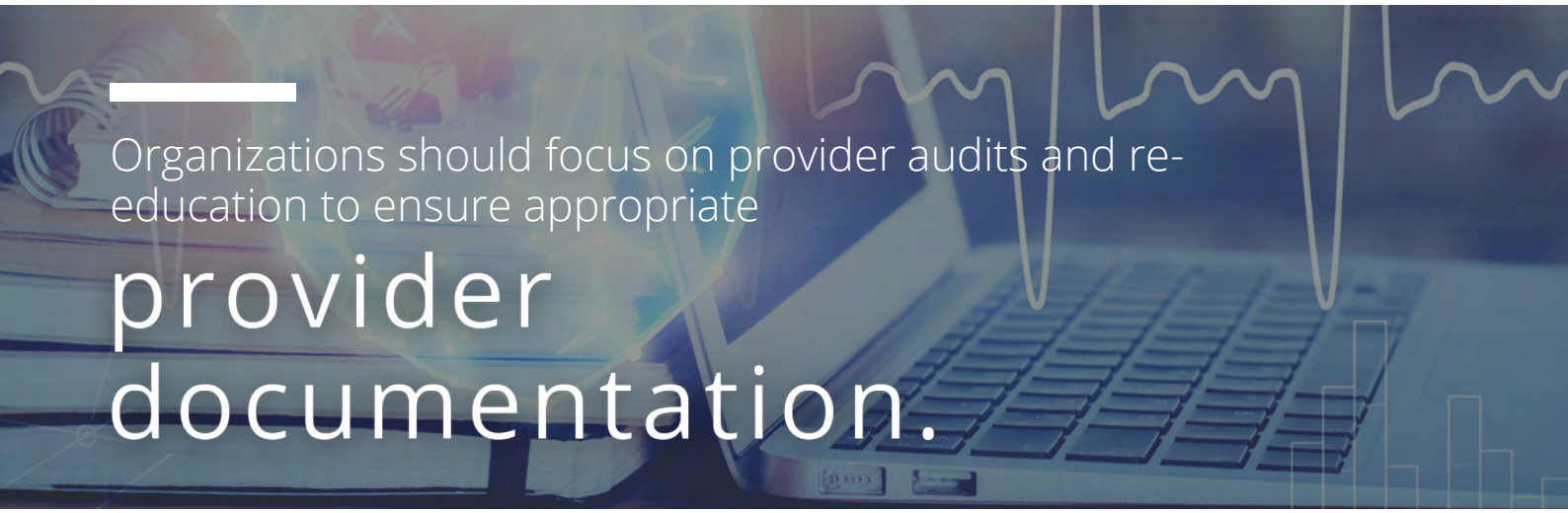
If you are working on which quality metrics to include in an arrangement, see additional information in VMG Health's article on Quality Metrics & FMV.

Top Coding Concerns with Physicians

A major part of compliance and area of regulatory scrutiny is coding properly. There are countless investigations and settlements associated with miscoding, whether intentional or not. Between the changes to the 2021 MPFS and the surge in telehealth, this is an important time to educate physicians on proper coding. From a strategic perspective, there are ways to optimize revenue with accurate coding as well.



2021 Evaluation and Management (E/M) Documentation Guideline Changes

It has been over 25 years since we've seen changes to the E/M guidelines. The Centers for Medicare and Medicaid Services (CMS) and American Medical Association (AMA) guideline changes effective January 1, 2021, have significantly impacted provider documentation and workflows, including operational and administrative. These changes are part of the CMS "Patients over Paperwork Initiative" to reduce administrative burdens on providers and make healthcare more efficient and patient centric.

The new guidelines have eliminated history and exam as required elements for leveling a visit. Providers now only need to document a clinically relevant history and exam. The E/M code selection is based on medical decision making (MDM) or total time spent on the day of visit. Both the MDM and time guidelines have changed considerably.

Over the last year, organizations have focused largely on educating providers, coders and billers. However, CMS, AMA and the local MACs have provided further guidance and clarification about the guidelines following the January 1st implementation. In fact, the AMA issued significant technical corrections on March 9th. These updates have caused confusion and inappropriate use of the guidelines, causing incorrect leveling by providers and coders.

Organizations should focus on provider audits and re-education to ensure appropriate provider documentation and accurate level of service assignment. In addition, documentation templates should be reviewed and updated to accommodate the new guidelines and facilitate provider documentation, along with workflow assessments and adjustments.

Shared/Split E/M and Incident-to Services

One of the significant impacts of the 2021 changes is the updated shared/split E/M guidelines. Previously, shared/split services were not permitted in the office setting. Based on the CMS and AMA guidelines, Physicians, and Advanced Practice Providers (APPs) can now share an E/M service based on MDM or time. The crucial area to highlight is that each provider, Physician, and APP, must document their own note. They need not repeat the documentation, but their separate note should clearly indicate their participation in the visit. Provider education, documentation template updates and workflow adjustments are recommended to ensure compliance with the guideline changes. It is important to note that the shared/split guidelines do not apply to consultations or procedures.

The 2021 changes have not affected the incident-to guidelines. The guidelines continue to be a challenge and risk are for most organizations. The incident-to rules require a physician to provide an initial service and establish a plan of care to be followed the APP, Physician in the suite and maintain direct supervision when the APP is seeing the patient, APP to see only established patients with no new problem(s) or change to the plan of care. Most organizations are moving away from billing incident-to services and promoting independent billing by APPs.

Telehealth Services

CMS defines medical necessity as “health-care services or supplies needed to diagnose or treat an illness or injury, condition, disease, or its symptoms and that meet accepted standards of medicine.” The AMA states “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.”

Medical Necessity

CMS defines medical necessity as “health-care services or supplies needed to diagnose or treat an illness or injury, condition, disease, or its symptoms and that meet accepted standards of medicine.” The AMA states “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.”

Medical necessity is the overarching criterion for payment, in addition to the individual requirements of a CPT code. For organizations and providers to ensure compliance and maintain the revenue integrity of services performed, routine audits and provider education is recommended. Specifically in high-risk areas such as Chronic Care Management (CCM), Transitional Care Management (TCM) and House Call services.

It is clear there are significant revenue opportunities associated with proper coding. Just as important, compliance with payor coding to survive an audit is essential for any healthcare organization. VMG Health has the expertise and resources to assist with both implementing and training teams to optimize revenue and compliance associated with provider coding.

More Individual Accountability

Historically, the United States government has focused primarily on hospitals and health systems in pursuing legal cases of health care fraud. In recent years, however, individual participants are increasingly being held legally accountable in these cases.

Sally Quillian Yates, the Deputy Attorney General of The Department of Justice from 2010 to 2015 issued a memorandum in June 2015 titled "Individual Accountability for Corporate Wrongdoing". In this memorandum, Yates stated:

> *"One of the most effective ways to combat corporate misconduct is by seeking accountability from the individuals who perpetrated the wrongdoing. Such accountability is important for several reasons: it deters future illegal activity and incentivizes changes in corporate behavior, it ensures the proper parties are held responsible for their actions, and it promotes the public's confidence in our justice system."*

In fiscal year 2019 and 2020, settlements illuminated the government's focus on individuals, including both physicians and senior executives or owners, and their participation in health care fraud. In aligning with

providers through various arrangements, it is important to educate these providers on their individual benefits of ensuring compliance within these arrangements, including compliance with the fair market value standard.

HMA & Dr. Glenn A. Kline

Following a $260 million settlement with Health Management Associates ("HMA"), the Department of Justice ("DOJ") negotiated a $4.25 million settlement with Dr. Glenn A. Kline, D.O. and his surgical practice, Community Surgical Associates, to resolve allegations that he violated the False Claims Act and Anti-Kickback Statute. To secure Dr. Kline's referrals, HMA allegedly paid Dr. Kline in excess of fair market value of his services and paid additional amounts to benefit his practice. Specifically, Dr. Kline was being paid 300% more than the Medical Group Management Association ("MGMA") median salary for comparable general surgeons and no fair market value analysis was done to support this payment. In addition to his excessive salary, Dr. Kline demanded, and was paid, additional amounts to benefit his practice. The funding arrangements were allegedly structured to disguise payments that were, in actuality, payments for patient referrals rather than for legitimate services.

In relation to this case, First Assistant U.S. Attorney Jennifer Arbittier Williams stated:

> *"The alleged improper physician inducements that Dr. Kline demanded, and received, are a form of 'pay to play' business practice that could compromise professional judgment. In sum, this conduct must be rooted out because it interferes with a physician's ability to provide top-notch patient care to American citizens."*

OK Compounding, LLC & Certain Physicians

There were numerous providers involved in arrangements with OK Compounding, LLC agreed to pay over $1.4 million to resolve allegations that they received payments disguised as medical director fees from OK Compounding, LLC in exchange for prescribing pain creams. The payment amounts ranged from approximately $50,000 to over $600,000 per provider. In relation to the case, U.S. Attorney Trent Shores stated:

> *"Eleven kickback settlements and counting. The manipulation of our federal health insurance programs cannot be tolerated. There are clearly defined laws and standards that must be followed when prescribing compounding medications. Greedy doctors and marketers who have conveniently ignored those laws for their own personal enrichment will be held accountable."*

Documenting that physician compensation is fair market value has always been a critically important part of physician alignment strategy. With the changes in the healthcare industry over the recent years, it is imperative for organizations to review and update the processes in place by which they determine provider compensation. Further, increased legal scrutiny on individuals highlight the importance of having compliant arrangements, which includes adhering to the fair market value standard. VMG Health has extensive experience in working with legal and compliance, as well as strategic teams to determine fair market value for both regulatory and planning purposes for any type of physician arrangement.

DOJ's Updated Evaluation of Corporate Compliance Programs

When regulatory authorities update guidance, it signals areas that may soon be scrutinized and provides important insight as to how to stay compliant.

In April 2019, the Department of Justice (DOJ) updated the original February 2017 guidance by organizing the key topics into three (3) "fundamental questions" that should assist prosecutors in evaluating an organization's corporate compliance program. In June 2020, there were some notable changes to the language of DOJ's guidance; however, the core structure and overall content of the guidance remains unchanged.

1. "Is the corporation's compliance program well designed?"
   This part of the guidance highlights that the elements of a well-designed compliance program include the following: risk assessment, policies and procedures, appropriately tailored training and communications, confidential reporting structure and investigation process, third party management, and mergers and acquisitions (M&A). Organizations should review their compliance program to ensure it encompasses the key elements outlined by the DOJ. Further, periodic review and update of the compliance program would be beneficial as the DOJ mentions frequently in the guidance to review "how the company's compliance program has evolved over time" and whether processes have "changed over time".

2. "Is the corporation's compliance program adequately resourced and empowered to function effectively?"
   An effective compliance program will encompass commitment from senior and middle management to develop a culture of compliance. The compliance team should have adequate resources and

autonomy to accomplish the various day-to-day tasks associated with overseeing a compliance program. Further, the compliance program should include incentives for compliance and disciplinary measures for non-compliance.

3. "Does the corporation's compliance program work in practice?"
This last guidance provides criteria to assess whether a compliance program is effective in practice. Aside from leadership commitment, an effective compliance program has the "capacity to improve and evolve." A compliance program should include continuous improvement, periodic testing and review, investigation of misconduct, and analysis and remediation of any underlying misconduct.

According to the DOJ, every organization's "risk profile and solutions to reduce its risks warrant particularized evaluation." There are various factors that will be taken into account when assessing compliance programs, such as: "the company's size, industry, geographic footprint, regulatory landscape, and other factors, both internal and external to the company's operations, that might impact its compliance program."

In summary, organization leaders should utilize the updated guidance as a resource and tool to assist with periodic, proactive reviews of their compliance controls. An effective compliance program is vital to an organization's success, especially during crises.

VMG Key Take-Aways:

The Latest in Regulatory Guidance

Regulatory guidance has always been a critical part of any physician alignment strategy, and the potential inducement of physician referrals is still a significant concern for the government. In addition, an emphasis on intent is a fundamental part of compliance and can be addressed by keeping your compliance program updated and communicated across your organization. Lastly, key tenets to any compliance program should include education on the fair market value requirement and proper coding.

Bottom Line

Physician Alignment Tips & Trends (PATT) 2021

Physicians are at the center of nearly every healthcare strategy, making alignment critical. To achieve financial viability with physician strategy, leaders should understand the reimbursement changes associated with the 2021 MPFS and the value-based care movement. It is also important to consider what COVID-19 has brought in terms of new challenges such as increased physician burn out, and benefits, such as telehealth. Finally, the latest regulatory guidance, new challenges with survey data, and progressive physician compensation models are all areas for healthcare executives to focus on when preparing for the future.

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