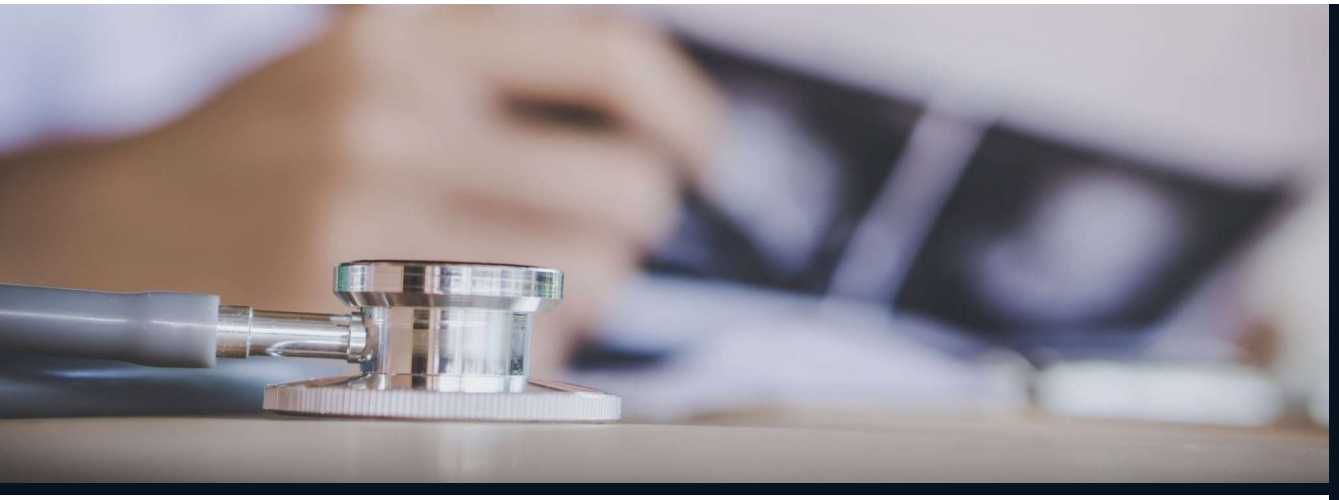

Common Pitfalls in Medical Practice: What Not to Do

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MCK Health Strategies, LLC

MGMA Connecticut Best Practices Symposium

Mystic, Connecticut November 7, 2024

9:00 AM – 10:00 AM

MCK HEALTH STRATEGIES LLC

Blue Cross Blue Shield Antitrust Litigation (MDL No. 2406)

Injunctive Relief ($100s of Millions of investment):

- BlueCard Transformation
- BlueCard Prompt Pay Commitments
- Service Level Agreements
- BlueCard Executive
- Real-Time Messaging System
- National Executive Resolution Group
- Out of Area Relief (Contiguous area rule, all product clause limitation for green business, expansion of contiguous area to affiliated hospitals)
- Third-Party Information
- Minimum Data Requirements
- Blue Plan Common Appeals Form
- Pre-Authorization Standards
- Telehealth Relief
- Minimum Level of Value-Based Care and Best Practices for Value Based Care
- 5 Year Compliance, Monitoring and Reporting

Common Pitfalls: **DON'TS and Dos**

- Correct Coding
- Lack of updating of Superbill (rates/charges)
- Prior-Authorizations and Claims Denials
- No Surprises Act (NSA)
- Virtual Care, Remote Monitoring and Chronic Care Management
- Insurer/Third Party Payer (and Employer) Contracting
  - Value-Based Care (VBC) Contracting
- Payment Plans for Patients
- Succession Planning/Partnership Development and Management/Leadership Training
- Lease Renewal/Office Space Rental
- Supplies and Equipment (group purchasing)
- Joining MSO/IPA/PHO/ACO
- Ownership and Private Equity Investment

Correct Coding: CPT and ICD 10 CM

Pitfall: Using outdated CPT and ICD 10 CM codes and information for the documentation, reporting, and billing of clinical services.

- CPT 2024 is the most recent revision of the work that first appeared 1966. CPT descriptive terms and identifying codes (the CPT code set) is useful for administrative management purposes such as claim processing and is a unform approach or language to describe the care (services, procedures) provided to patients. In 2000, the CPT code set was designated as the national coding standard for physicians and other healthcare professional services and procedures under HIPAA.
  - The Current Procedural Terminology (CPT) code set for 2024 included **349 editorial changes**, which is made up of **230 new codes, 70 revisions, and 49 deletions**. These changes went into effect on January 1, 2024.

- ICD-10 stands for International Classification of Diseases, Tenth Revision, and is a global system for coding diseases, symptoms, procedures, and causes of death.
  - The 2024 ICD-10-CM code set update **includes 395 new codes, 25 deletions, and 22 revisions.**

Superbill/Chargemaster

Pitfall: Not updating your Superbill/Chargemaster with new, revised and deleted CPT and ICD 10 CM codes and failing to evaluate and update charges.

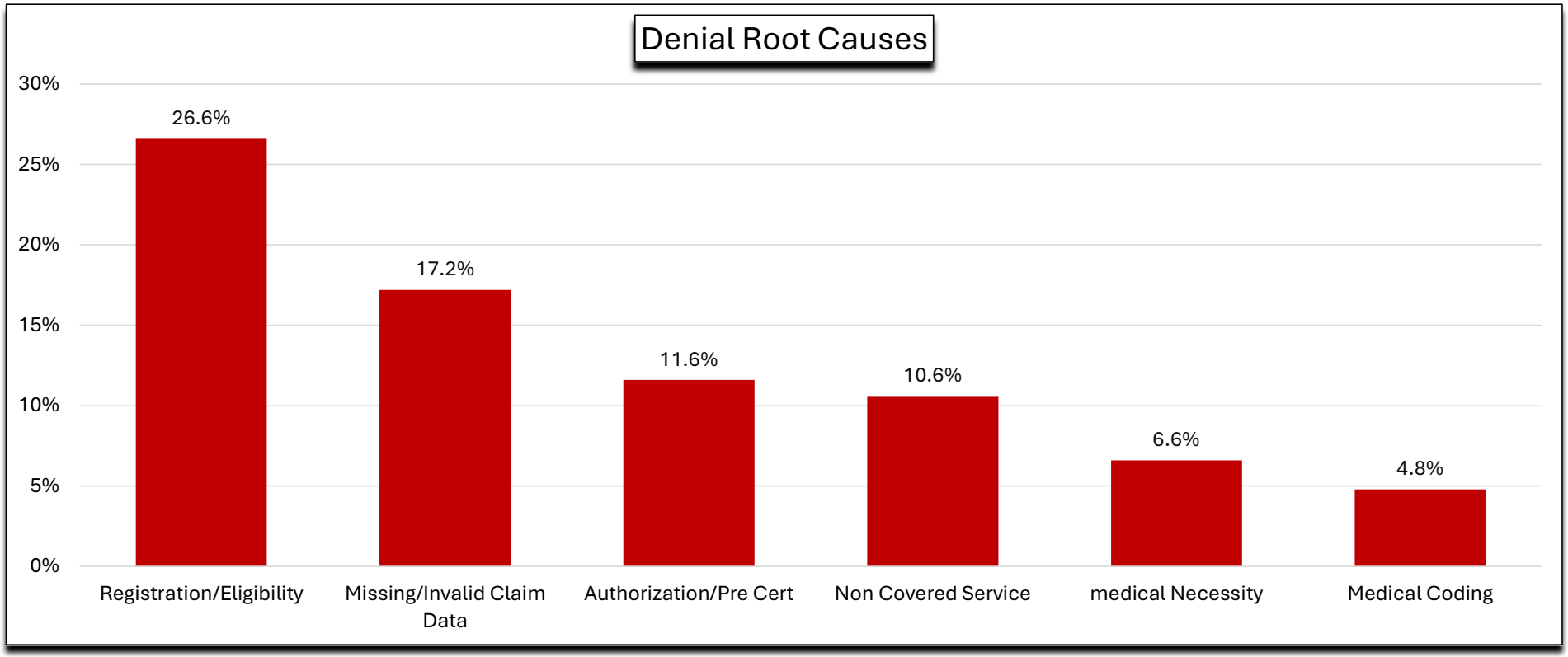
- A superbill itemizes and details the services you provide a patient, which gives the insurer the information they need to decide whether to provide superbill reimbursement. Meanwhile, the patient typically pays your practice up-front for the services. A chargemaster, also known as a charge description master (CDM), is a list of billable services and items for a physician practice that includes the price for each item. The chargemaster or superbill lists each service's item number, description, charge amount, and other details.
- Is this outdated because of electronic billing and EMRs? No- you still need to continuously review and update (annually) to make sure not only that the correct codes are being used and billed but also that your rates/charges are up to market and reflect the level of decision making, your skill, expertise and work involved in the care and treatment of your patients. You need to analyze your costs of care annually and adjust your superbill (charges) tied to individual services to reflect those costs (sometimes they go down).
- It also provides transparency to patients. The chargemaster details the prices for services before they are administered, helping patients understand what they will be expected to pay (online version provides that advanced information or upon request).
- Poor maintenance can lead to revenue leakage, overpayments or underpayments, claim rejections, and more.

Prior Authorization and Claims Denials

Pitfall: Not appealing prior authorization denials or claims denials in general.

- According to available data, a significant portion of medical services, particularly within Medicare Advantage plans, require prior authorization, with estimates suggesting that between **30% and 70%** of services across different categories may need prior authorization depending on the specific service type, with most services seeing an increasing trend in prior authorization requirements over time. However, the exact percentage varies widely based on the insurer, insurance type and the type of service being requested. While a large percentage of services require prior authorization, most requests are typically approved (at least eventually), with studies showing more than **90%** of prior authorization requests receiving full approval in some cases.
- A recently completed national survey found that at least one and in ten claims is denied and some organizations are seeing more than **15%** of claims denied but there is some variability based on the type of insurer.
  - Medicare Advantage: **15.7%**
  - Medicaid: 16.7% (national average)
  - Commercial: **13.9%**
- According to recent data, around **54.3%** of healthcare claim denials from private payers are eventually overturned and paid, although this often requires multiple rounds of appeals by providers to achieve this outcome.
- Another recent study found that clinicians often incur significant costs to fight denials, with an average cost per claim of around **$43.84.**

Claims Denials 2019 - 2020



No Surprises Act

Pitfall: Expecting the No Surprises Act (NSA) to fix/solve all your out of network payment issues with health insurers.

The No Surprises Act (NSA) is a federal law that went into effect on January 1, 2022, to help patients understand their health care costs and reduce surprise medical bills. The NSA protects patients from surprise bills and was supposed to help physicians get paid for out of network services through a defined federal process.

(https://www.cms.gov/nosurprises/policies-and-resources/overview-of-rules-fact-sheets)

- Emergency services
  - Patients only pay their in-network copayment, coinsurance, or deductible for emergency services.
- Out-of-network providers
  - Patients are protected from surprise bills when treated by an out-of-network provider at an in-network hospital or ambulatory surgical center.
- Balance billing
  - Patients are protected from balance billing, which is when a provider sends a bill to a patient for the difference between what the insurance plan agreed to pay and the full cost of a service.
- The NSA also covers non-emergency services provided by out-of-network providers at in-network facilities.
  - Has not worked as expected with significant problems with federal implementation resulting in several lawsuits filed by the Texas Medical Association (TMA) and several other organizations, associations, facilities and physicians.

Virtual Care: Telehealth/Telemedicine/RPM/RTM and more

Pitfall: Jumping headfirst into virtual care or not evaluating at all for opportunities to improve patient access to care and care delivery (experience) as well as practice revenue.

- The Health Resources Services Administration defines **telehealth** as the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.
- **Telehealth** is different from **telemedicine** because it refers to *a broader scope of remote healthcare services* than telemedicine. While telemedicine refers specifically to remote clinical services, telehealth can refer to remote non-clinical services, such as provider training, administrative meetings, and continuing medical education, in addition to clinical services.
- Telehealth essentially encompasses telemedicine and it is different from telemedicine in that telehealth refers to a much broader scope of remote health care services than telemedicine.
- Telemedicine refers specifically to remote clinical services via video and/or audio telecommunications technologies and connection (imaging, internet use, streaming, etc.), while telehealth can refer to remote clinical and non-clinical services at a distance including patient monitoring as well as provider training and continuing medical education.

Virtual Care: Telehealth/Telemedicine/RPM/RTM and more

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- **Remote Patient Monitoring (RPM)** is the umbrella term used for a variety of remotely delivery activities in patient care using technology to collect and send patient-generated data to clinicians who treat and provide care to patients, often outside of traditional medical settings.
- Statutory term RPM- **"remote physiologic monitoring"-** focusing on the patient's physiology (and what is being communicated). RPM generally means on-body (or in-body) FDA- defined (not necessarily approved) medical devices to passively and automatically receive, collect, and report physiologic readings to physicians (and other clinicians and entities): **Temperature; Blood Pressure; Pulse Oxygen; Blood Glucose Level; Weight.**
- Physicians (and their staff or third-party vendors) monitor these devices (the readout data) to inform patient care and develop a care plan and to facilitate proactive clinical interventions.
- CMS introduced RPM billing codes (and payment) in the 2019 Medicare Physician Fee Schedule (PFS), allowing physicians to reimburse for the care management services related to remote patient data (collection) but also for the devices themselves, as well as the time spent training/coaching patients on their use. Over the last few years during COVID-19 Pandemic, the codes further clarified that this monitoring could be used for most diseases (disease states) and medical conditions.
- **Remote Therapeutic Monitoring** was introduced by CMS in November 2020 (for 2021) to further enhance remote care delivery. Sometimes called *Remote Treatment Monitoring*, RTM codes monitor specific health conditions, such as musculoskeletal system status, respiratory system status, therapy adherence (including medication) and therapy (including medication) response. Non-physiologic data is (can be) collected and technically, some of this data can be self reported (by the patient), but is generally digitally uploaded in some fashion.
- While RPM is focused solely on physiologic status, RTM focuses on a patient's therapeutic status (think adherence and the response to treatment/therapy). Most of the RTM programs, while still relatively brand new, are virtual programs focusing on medication adherence, pain management and respiratory care (video observed adherence, etc.).

Virtual Care: Telehealth/Telemedicine/RPM/RTM and more

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- Significant expansion of telehealth initially in response to the COVID-19 pandemic, followed by a dip in use and an increase in RPM and some RTM services that are starting to impact health care delivery at the point of care.
- Medicare, Medicaid, and private payers have changed their telehealth coverage and payment requirements at a dizzying pace and the same can be said for RPM and RTM, especially as more focus is paid to care coordination models and value-based care arrangements.
- Medicare looks to make additional changes for 2025 tied to recent changes in CPT codes, but the medical community is still waiting on the Medicare Fee Schedule Final Rule (MFS).
- Settings, Services (Scope), Technologies, Clinicians, Frequency, Patients, Documentation, Coding, Reimbursement, and Coverage all changing (state, federal and commercial).

Virtual Care: Telehealth/Telemedicine/RPM/RTM and more

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- Recent polls indicate that roughly half of seniors (Medicare eligible patients) are comfortable using telehealth to get medical care, and those that do largely say they had a favorable experience.
  - Poll conducted of more than 1,000 seniors and found **52%** are comfortable using telehealth for their healthcare, with 30% uncomfortable and another 18% unsure.
  - Among those surveyed who had used telehealth services, **91%** said they had a favorable experience with telehealth, and **78%** indicated they plan to do so again.
  - 73% of seniors on Medicare Advantage (MA) indicated they had their healthcare needs addressed either by telehealth or in person.
- A 2022 study by Merritt Hawkins reported that **48%** of physicians were treating patients using some form of telehealth services up from merely 18% in 2018.
- Blue Cross Blue Shield of Western New York indicated it experienced only 135 telehealth visits in March 2019 across its membership but by March of 2020 there were **20,000 telehealth visits** occurring monthly.
- Blue Cross Blue Shield of Massachusetts saw a massive spike in telehealth usage due to COVID-19 and processed **1 million claims** for telehealth in first nine weeks of the pandemic, approximately **38,000 per day**. Close to **half** of those claims were for virtual behavioral and mental health services.

Virtual Care: Telehealth/Telemedicine/RPM/RTM and more

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- There are some barriers to RPM/RTM that are similar to telemedicine and basic telehealth services, but it seems that ***digital health literacy*** and technology access (including internet service) are major barriers to the implementation and use in patient homes. ***Digital health literacy*** generally refers to the level of comfort and confidence that people have in using technology and engaging in the digital experience for their health and wellbeing.
- The often lack of technical support is also an issue facing RPM/RTM (even if they are educated/trained in the physician office setting initially or at home tied to a home care professional).
- If you have low digital health literacy you may be apprehensive or even opposed to RPM and RTM devices and health care services.
- Almost **35 million Americans** lack internet access and many millions more have limited access.
- Amazon, Walmart, Microsoft, CVS, Walgreens and even Best Buy got into the virtual care arena and all rapidly expanded their virtual care offerings to consumers (much of this is consumer directed and consumer focused) but most of these companies have pulled back in the last six months.

Virtual Care: Telehealth/Telemedicine/RPM/RTM and more

Pitfall: Jumping headfirst into virtual care or not evaluating at all for opportunities to improve patient access to care and care delivery (experience) as well as practice revenue.

- Virtual care patient management and quality reporting should be structured in such a way that they are integrated not only with the home medical devices provided to patients but also existing in office practice management and care management systems.
- Make sure that the devices and more specifically the data being analyzed by the practice (submitted from or by the devices) can connect to existing systems and the data is transferable (be careful to make sure that the data is readable/interpretable not just when it comes into the practice for physician or clinician review, but also when it enters your existing systems for documentation and reporting of care delivery (EMR, billing system, etc.).
- Make sure that the digital health platform that is used is the right mix of technology and care. Sometimes these RPM devices or solutions are one offs and do not integrate into practice health information technology solutions and if each device is a standalone platform, it makes combining the data and interpreting it together very difficult.
- Make sure the system being used includes care plans and assessments, quality reporting, patient outreach opportunities, even some home care support.
- If anything needs prior authorization/prior approval and/or ongoing approval (for continuation of care delivery), make sure that information from the RPM and RTM is able to be submitted easily and effectively to the payer.
- In general, each patient is a different case or example and need to focus on what that patient may need in the way of RPM/RTM services.
- A single remote patient monitoring patient could generate as much as $3,000 annually assuming the maximum services are provided monthly and reported correctly. However, there is clearly a range and many patients will have associated annual claims of closer to $1,000 based on their need and the physician's evaluation of data and the associated clinical monitoring.

Virtual Care: Telehealth/Telemedicine/RPM/RTM and more

Pitfall: Jumping headfirst into virtual care or not evaluating at all for opportunities to improve patient access to care and care delivery (experience) as well as practice revenue.

According to **the AMA Digital Health Implementation Playbook,** a necessary first step is to identify your patient population's specific needs. Then, forming a team at your practice location or across multiple practice locations (depending on your practice structure) and then work to:

- defining goals
- designing the workflow
- developing or implementing a platform to remain connected to patients and to allow RPM data to flow between the patient and the practice.

The American Medical Association **recommends finding a vendor** that will be a long-term partner. There are six common variables that physicians should consider when evaluating vendors:

- Business
- Information technology
- Security
- Useability
- Customer service and
- Clinical validation

Virtual Care: Telehealth/Telemedicine/RPM/RTM and more

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- Devices
  - Pick the right devices for your patient population (not the new shiny toy or new something or other that does not relate to your clinical practice).
  - How will device(s) make it to the patient (provide at the office, deliver to home, etc.)?
  - Connectivity
  - Device Support
  - Device Security
- Data
  - Frequency
  - Review
  - Liability
  - Quality
  - Storage
- Dialogue/Communication
  - Communication with Patients
  - Emergency situations
  - Using Bots and other automation
- Financial Considerations
  - Payment
  - Costs/Resources
  - Investment/Partnership/Third Parties

Modified from *The Ultimate Starter Kit for Remote Patient Monitoring*- Sudipto Srivastava, Feb 17, 2022

Physician Insurer Contracting

Pitfall: Your health insurer contract. Read and negotiate your contract. If you want or need something you need to ask for it (reimbursement or otherwise). If you do not ask you will very likely never receive and if you have a question, ask, now is the time (not after you sign).

- Most physicians do not read their insurance contracts (especially if they have an attorney or consultant engaged). It is critical as the party responsible for upholding the "provider" responsibility that you (office manager and managing partner) read the contract and all associated documents (addendum, exhibits, etc.). It is unfortunately a buyer beware situation with contracts for service and you never know what could be added/thrown in.
- Make sure you know which products, plans, networks you are agreeing to be in network with and what are the rates for each (they often differ). Understand if there is network tiering and what network tier you are in.
- Many physicians believe that insurer contracts today are take it or leave it, but the reality is that there are things within the contract that are negotiable (even the rates). Items like term of the contract, certain service or patient carve outs, even networks are areas of discussion today and often negotiation. Do not leave things on the table by not asking but you need to be reasonable/rational in your request/ask.
- AMA has a good contracting guide (managed care contracting) that helps you think of areas of concern and areas of focus.
- Be careful when selecting a consultant and/or an attorney- negotiating an insurance contract is not like completing an estate will, attorneys like physicians specialize.
- There are several different models today for contracting for reimbursement, including value-based care/shared savings, it is important to understand what these are and how they work.

Value-Based Care and Shared Savings

Pitfall: Signing a Value-Based Care and/or Shared Savings Contract without understanding the provisions. Before you sign, understand the terms and approach. It is often better to crawl before you walk and do not run if you do not have any experience in this area of contracting/service provision (consider staying away from downside risk at first- glide path approach).

Value-based care (VBC) is a health care delivery model that focuses on improving the quality of care, patient experience, and clinical performance. It's different from the traditional fee-for-service model, where physicians are paid for each medical service they perform. In VBC, physicians are paid based on the quality of care they provide and the health outcomes of their patients.

Here are some key aspects of VBC:

- **Patient-centered-** managing a patient's overall health and considering their personal health goals.
- **Population health**- managing a population of patients, rather than providing transactional care for individual patients.
- **Proactive care**- preventing problems before they start.
- **Wellness and prevention**- emphasis on wellness and prevention, such as quitting smoking, exercise, and dietary changes.
- **Integrated care**- helps patients avoid the emergency departments and hospital care by coordinating care and creating integrated care pathways.
- **Data analytics**- uses data analytics and digital health records to help manage a population.
- **Incentives-** Physicians can earn incentives for providing high-quality care. Some models have upside-only risk, where physicians gain revenue if they exceed quality, cost, or equity targets. Other models include downside risk where you can lose revenue for missing patient care or cost of care targets.

Patient Payment Plans/Bad Debt

Pitfall: Today, with the increase in the number and cost (maximum deductible) of high deductible health plans, more and more practices are experiencing patient bad debt and lack of payment.

- A high-deductible health plan (HDHP) in 2024 must meet the following requirements:
  - **Deductible**: A minimum of $1,600 for self-only coverage and $3,200 for family coverage
  - **Annual out-of-pocket expenses**: A maximum of $8,050 for self-only coverage and $16,100 for family coverage
  - **Employer contributions**: A maximum deduction of $8,300 per year for individuals with family coverage
- Most Americans have faced healthcare debt. According to the Kaiser Family Foundation, 57% of U.S. adults owed healthcare debt in the past five years, and 4 in 10 currently have debt due to medical or dental bills.
- Most bad debt is associated with insured patients. According to public accounting firm Crowe, self-pay after insurance accounted for nearly 58% of bad debt in 2021, compared with only 11% in 2018.
- A patient payment plan is a way for patients to pay for medical bills in installments over time instead of in a lump sum. Some benefits of patient payment plans include:
  - **Avoiding collections**: Patients can avoid having their medical bills sent to collections, which can negatively impact their credit score (changing).
  - **Getting care**: Patients may be more likely to get the care they need if they can finance the procedure.
  - **Breaking up payments**: Patients can break up their balance and pay it off over time.
- Some physician offices offer payment plans directly or through other lenders (banks, etc.). These plans can be interest-free or have deferred interest or act more like a credit card account (set up through a third party). Be careful about how some of these are presented as some do have up front interest charges or fees, but others waive those fees if payment is made on time or as scheduled.
- Here are some tips for healthcare providers offering patient payment plans:
  - Explain how the plans work to patients when they schedule an appointment or arrive for the visit.
  - Make sure you have information on your website, and have office signage, and follow up with an email.
  - Be proactive to help patients overcome any hesitation about the cost of healthcare.

Succession Planning

Pitfall: Not having an office plan of action for succession planning.

- Succession planning is a strategy for identifying and developing employees to take on leadership (and management) roles when they become vacant. It's a way to prepare for change and ensure that key positions remain stable, which can help the practice continue to achieve its goals. It is not just mentoring, though mentoring should be a part of an effective process.

- Here are some benefits of succession planning for medical practices:
  - **Business continuity**: Succession planning helps ensure that the practice can continue to operate even if a key person leaves or changes roles.
  - **Employee engagement**: Succession planning can help employees feel more engaged by providing clear career paths.
  - **Organizational stability**: Succession planning can help maintain stability during transitions.

- Here are some tips for succession planning for a medical practice:
  - **Identify critical roles**
    - Determine which roles are most important to the practice need potential successors (not just managing partner and/or practice manager).
  - **Create action plans**
    - Develop plans for how individuals can take on critical roles.
  - **Provide relevant work experience**
    - Include practical work experience in succession planning programs to prepare employees for future roles.
  - **Involve Practice Manager**
    - Practice manager will play a key role in succession planning by creating development plans, and monitoring progress.

Leadership and Management Training

Pitfall: Not providing leadership or management training to younger clinical and/or administrative staff.

- Leadership and management training are programs that help employees develop the skills and knowledge needed to lead and manage others in the medical practice, just like any other business setting or situation. These programs help professionals develop critical skills, such as goal setting, coaching, delegating and counseling, so they can excel in a management position.
- **Leadership training**
  - Helps employees transition into management roles by developing skills like goal setting, coaching, and delegating.
- **Management training**
  - Helps professionals develop the skills and knowledge to become managers, including communication, strategic planning, and problem-solving.
- Leadership and management training programs can help employees:
  - Improve their ability to influence, motivate, and lead their team
  - Increase their confidence in their ability to lead and manage others
  - Learn new leadership techniques and refine old skills
- These programs can be offered by academic institutions, professional organizations, or businesses. They can take many forms, including classroom training, online learning, coaching, mentoring, or a combination of these.

Supplies and Equipment (GPO)

Pitfall: Always buying from same distributor/company without checking around and not buying more items from a single distributor/company (volume matters) or signing and exclusive long-term relationship with a group purchasing organization.

- Group purchasing, also known as a group buying organization (GPO), is a business model where multiple companies join together to purchase goods and services at a discount. GPOs work by combining the purchasing power of their members to negotiate better prices from suppliers. This allows members to access products and services at a lower cost than they would be able to on their own.

- In addition to negotiating discounts, GPOs may also offer other services, such as:
  - Supply chain management
  - Procurement consulting
  - Logistics support
  - Electronic invoicing
  - Cost-savings reports
  - Trend analysis
  - Product standardization assistance
  - Budgeting tools

- Benefits of group purchasing include:
  - **Cost savings**: Practices can save money on their purchases without having to buy in bulk
  - **Streamlined procurement**: Practices do not have to worry about finding reliable suppliers or paying for overpriced products
  - **Access to a wider range of goods and services**: Members can access a wider range of products and services than they would be able to on their own

Lease Renewal/Office Space Rental (Ownership)

Pitfall: Not evaluating your office space for your needs on an annual basis and signing your renewal without checking on available options or requesting changes to the lease agreement (or allowing it to auto renewal when you may want/need changes)

A lease renewal is when a landlord and tenant agree to continue a rental agreement for another term. This can be done by signing a new lease with updated terms, or by continuing a month-to-month basis (though often not preferred by either party).

- **Lease type**
  - A fixed-term lease renewal is when a new lease is signed for a set period. A month-to-month lease allows either party to end the lease at any time with notice. Today, landlords are looking generally for 10-to-12-year leases (especially with newer properties) but it is hard to sign a lease for this term given the uncertainties of medical practice.
- **Renewal options**
  - A renewal option gives the tenant the right to extend the lease for a specified period of time. The option may have conditions, such as when the tenant must notify the landlord and it is important to check your existing lease for these terms of notice (sometimes without notice the lease will automatically renew for a specific term, usually a year but sometimes up to three years).
- **Property condition**
  - Before renewing, consider the condition of the property, including any maintenance issues or renovations that may be needed and were or were not performed by the landlord previously.
- **Annual increase**
  - Most leases will have an automatic annual increase built in as a percentage. Some may have variable increases based on certain conditions (some even specify how much a lease can go up tied to these conditions like consumer price index). It is better to focus on a lease rate increase that is known and can be planned instead of one that is variable based on factors out of your control.
- **Common area charges**
  - This is an area where increasingly physician practices are having issues with landlords because of open ended charge limitations (no limits or high annual increases), variable rate adjustments and factors (cost of electricity, property improvements, etc.). While improvements to property/building may be necessary and warranted, the financial impact of these could be staggering and could result in common area costs that match or exceed rental fees. It is important to try to cap these increases, to make sure the lease provides transparency of all increases in this area and there is a right to audit and dispute these costs (and the associated improvements).

MSO/IPA/PHO/ACO

Pitfall: Joining MSO/IPA/PHO/ACO for better efficiencies of practice management or improved contractual rates with health insurers to learn that the administrative intricacies, quality outcomes reporting and processes are more complex, time consuming, and resource intense than the potential (or actual) revenue improvements.

- MSO stands for **Management Services Organization**, which is a business that provides administrative and management services to healthcare practices. MSOs can be owned by hospitals, physician groups, payors, or joint ventures between hospitals and physicians.
  - **Administrative tasks**: MSOs can handle a variety of administrative tasks, such as billing, coding, claims management, and revenue tracking.
  - **Non-clinical support**: MSOs can provide non-clinical support, such as staff education and training, human resources, and risk management.
  - **Technology and infrastructure**: MSOs can provide the technology and infrastructure needed for healthcare practices to operate successfully.
  - **Discounts**: MSOs can provide access to discounted services and supplies due to their large volume.
  - **Liability and asset protection**: MSOs can help limit liability and improve asset protection.

- IPA stands for **Independent Physician Association** or Independent Practice Association, which is a business entity that's owned and operated by a network of independent physician practices. IPAs allow physicians to maintain their independence while still benefiting from the advantages of a larger group.
  - **Reduce overhead**: Can help reduce overhead costs by sharing the burden of administrative tasks like payroll and compliance.
  - **Access technology**: Can provide access to important information technology platforms and other opportunities.
  - **Negotiate reimbursements**: Can negotiate with third parties, such as insurance companies, to secure better reimbursements for their members.
  - **Advocate for policy changes**: Can act as an advocate for contractual and payment policy changes.
  - **Make large purchases**: Can help member practices pool resources to make large purchases.

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- PHO stands for **Physician Hospital Organization**, which is a legal entity that allows hospitals and physicians to work together on common goals. PHOs are generally owned (majority owned) by the hospital party engaged in the organization. PHOs can help improve the quality of care, streamline operations, and deliver better health outcomes for patients.
  - Develop health services arrangements with insurers and other payers
  - Create and implementing clinical integration strategies
  - Provide ongoing managed care strategies
  - Oversee the integration of hospitals and physicians into health delivery networks
  - Collecting, analyzing, and disseminating information

- An **Accountable Care Organization** (ACO) is a group of healthcare providers that work together to coordinate patient care.
  - **Goals** of an ACO are to provide high-quality, coordinated care to patients, while also managing costs and improving health outcomes.
  - **Benefits** of an ACO include helping patients save time and money by avoiding unnecessary tests and appointments. They can also help prevent medical errors and drug interactions through quality programs.
  - ACO providers **share information**, such as test results, treatments, and prescriptions, as well as certain cost of care data to help ensure patients receive the right care at the right time.
  - ACOs generally **use fee-for-service** as their base payment model, though most ACOs today also have some sort of gain sharing/shared savings arrangements with insurers, and many are working toward value-based care arrangements.

Physicians Advocacy Institute, Inc (PAI) Study

Avalere Health Analysis

- The body of research documents the profession's shift from predominately independent practice to nearly **78%** employment over the past decade according to the most recent study findings.

- 2012-2018: Hospitals and Health Systems Acquire Practices
  - Avalere analyzed the growing trend of hospital and health system ownership of physician practices and employment
  - By 2018, **44%** of physicians were employed by hospitals or health systems, up from **25%** in 2012.

- 2019-2021: Impact of COVID-19 Pandemic
  - Avalere expanded its analysis of practice ownership and employment to include the role of other corporate entities that began acquiring physician practices. These corporate entities include private equity firms, insurers, and other businesses, like CVS and Amazon.
  - Following the onset of the pandemic, there was a sharp increase in physician employment and practice ownership.
  - By 2022, nearly **74%** of physicians were employed, including **52%** by hospitals and health systems and **22%** by other corporate entities.

Avalere analysis of IQVIA OneKey database that contains physician and practice location information on hospital/health system ownership

Physicians Advocacy Institute, Inc (PAI) Study

Avalere Health Analysis

Latest Report Adds 2022 and 2023 Data to Ongoing Avalere Analysis

2022-2023 – Post-Pandemic

- New analysis incorporates two additional years of data from January 1, 2022, through January 1, 2024, and shows a continued trend of hospital acquisitions of physician practices and a slowing pace of growth in physician employment.
- Employment by hospitals and corporate entities is nearing **78%.**

Pre-COVID: From January 2019 to January 2020, there was moderate growth of physician employment and practice ownership by hospitals and higher growth among corporate entities

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Research Timeline – January 2019 to January 2024

Avalere has studied the five-year period between January 1, 2019, and January 1, 2024, to examine physician employment and practice acquisition trends, including after the COVID-19 pandemic.

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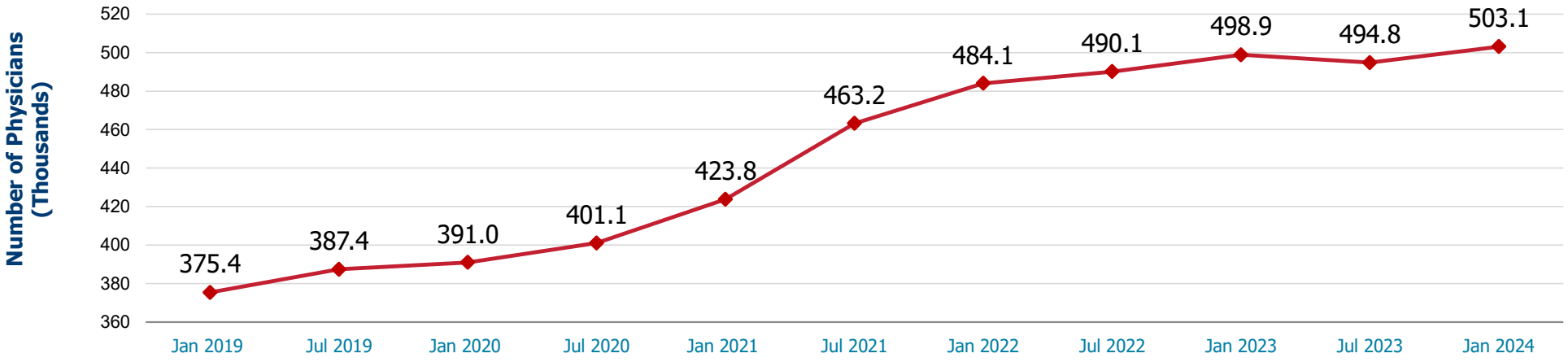
National Five-Year Trends: Employment Surges Post-Covid and Continues to Grow at Slower Pace, Now Exceeds 500,000 Physicians

NUMBER OF U.S. PHYSICIANS EMPLOYED BY HOSPITALS OR CORPORATE ENTITIES 2019-23



- **127,700** additional physicians were employed by hospitals or corporate entities over the five-year study period – **19,100** of that shift occurred after in the last two years
- Physician employment grew in each of the six 6-month periods analyzed, except for one
- The growth rate of hospital or corporate-employed physicians has moderated since January 2022

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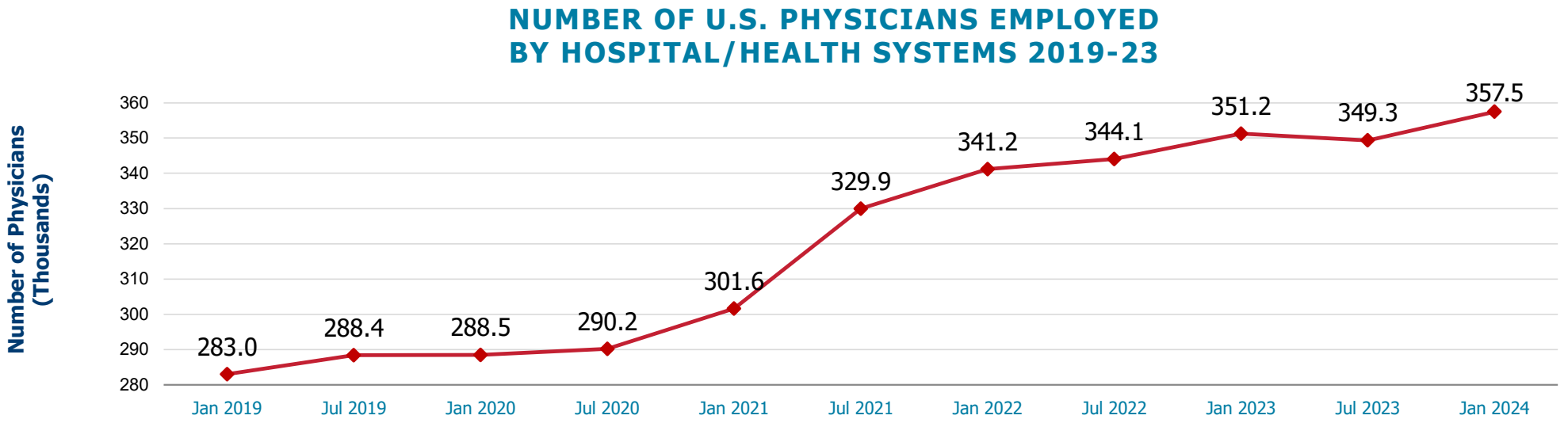
National Five-Year Trends: Steady Physician Hospital Employment Growth Spikes Post-Covid and Continues at Moderate Pace



- **74,500** additional physicians were employed by hospitals over the five-year study period – **16,300** of that shift occurred in the last two years
- Physician employment grew in each of the six 6-month periods analyzed, except for one
- The growth rate of hospital-employed physicians has moderated since January 2022, resembling growth prior to COVID-19

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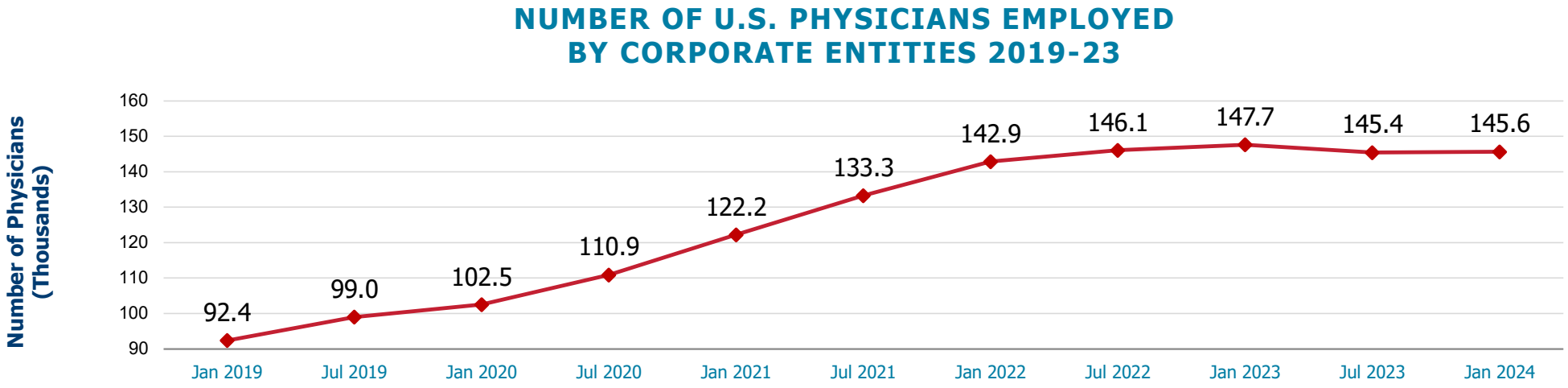
National Five-Year Trends: Sharp Growth in Corporate Physician Employment has Leveled Off Since January 2022



- **53,200** additional physicians were employed by other corporate entities over the five-year study period – **2,800** of that shift occurred in the last two years
- Corporate physician employment peaked in January 2023 and has leveled off
- The growth rate of corporate-employed physicians has been minimal over the last two years and was negative between January and July 2023

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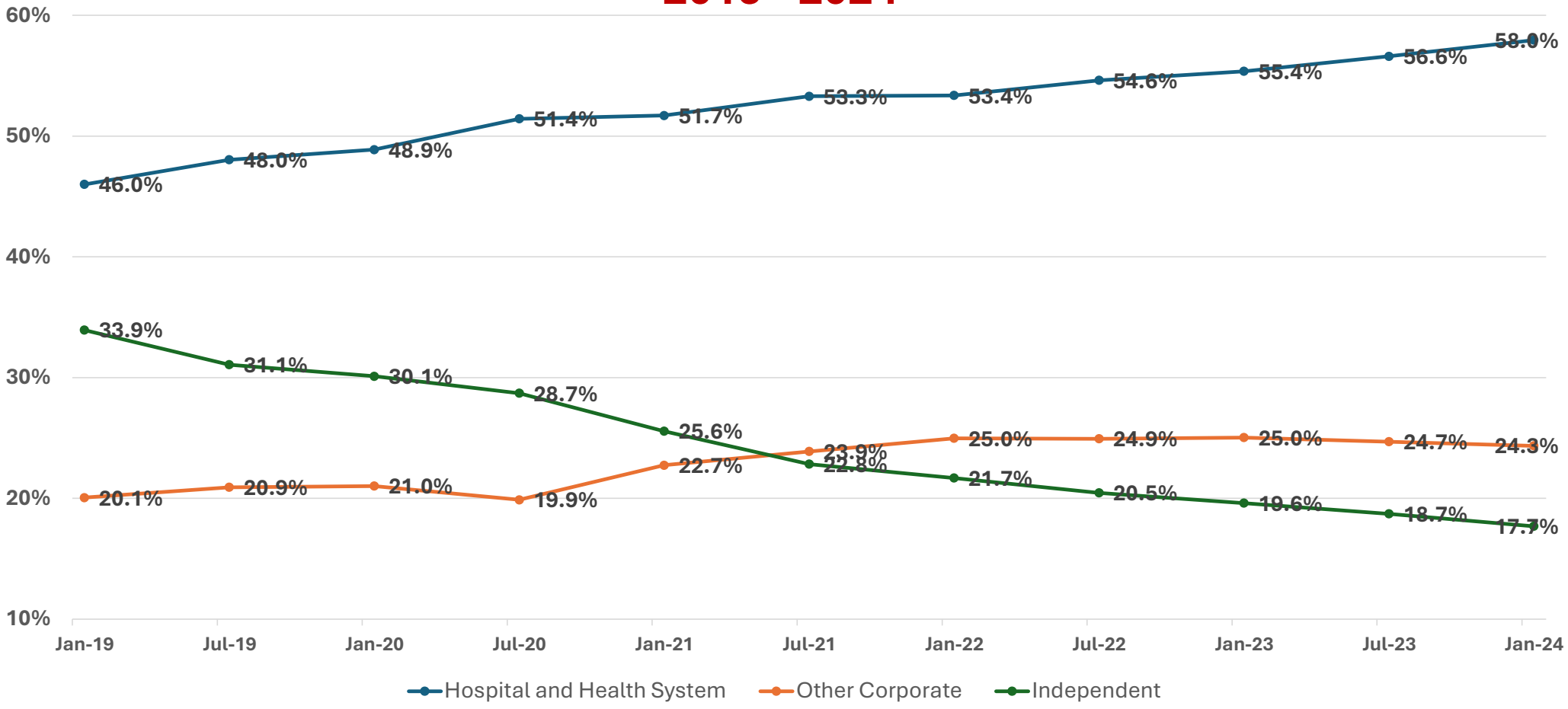
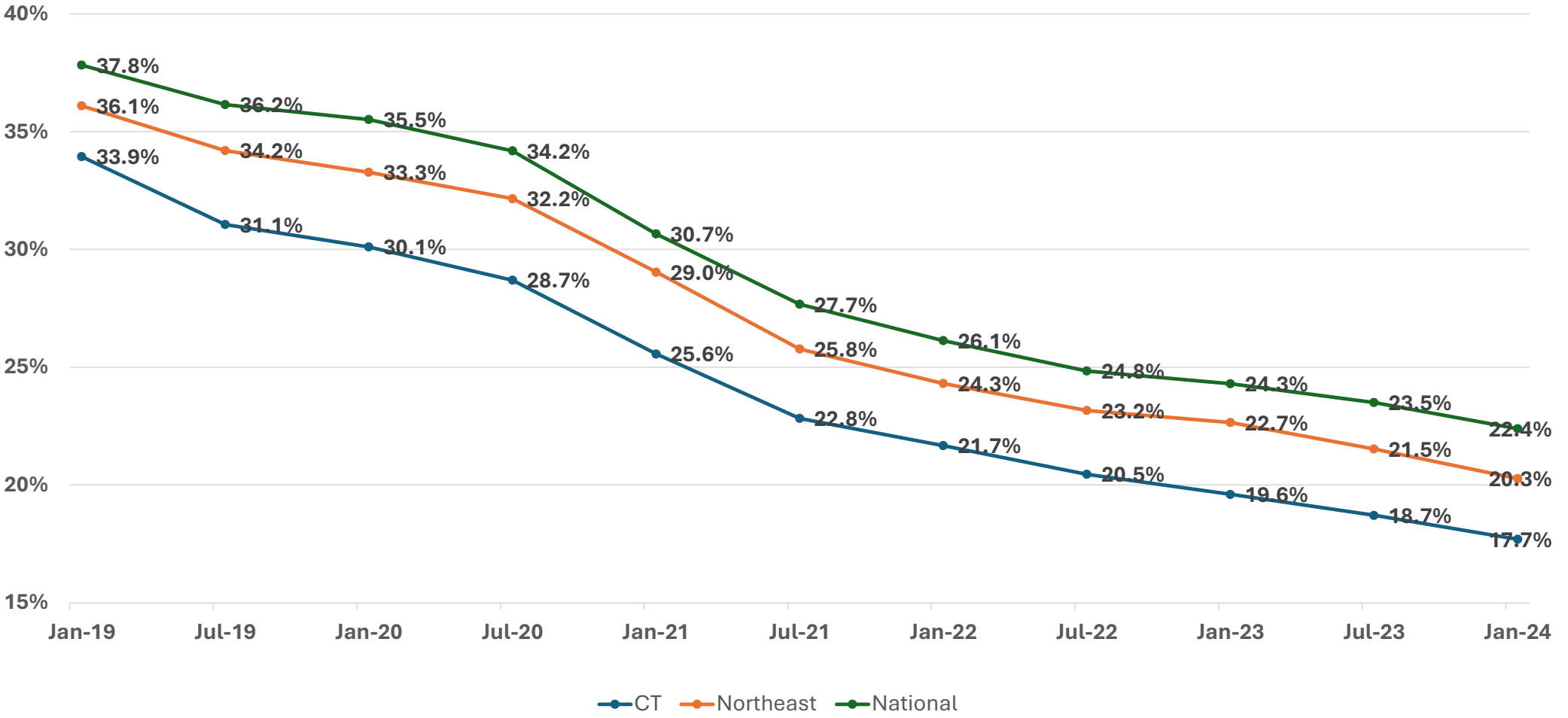
Connecticut Physician Employment By Employer Type 2019 - 2024



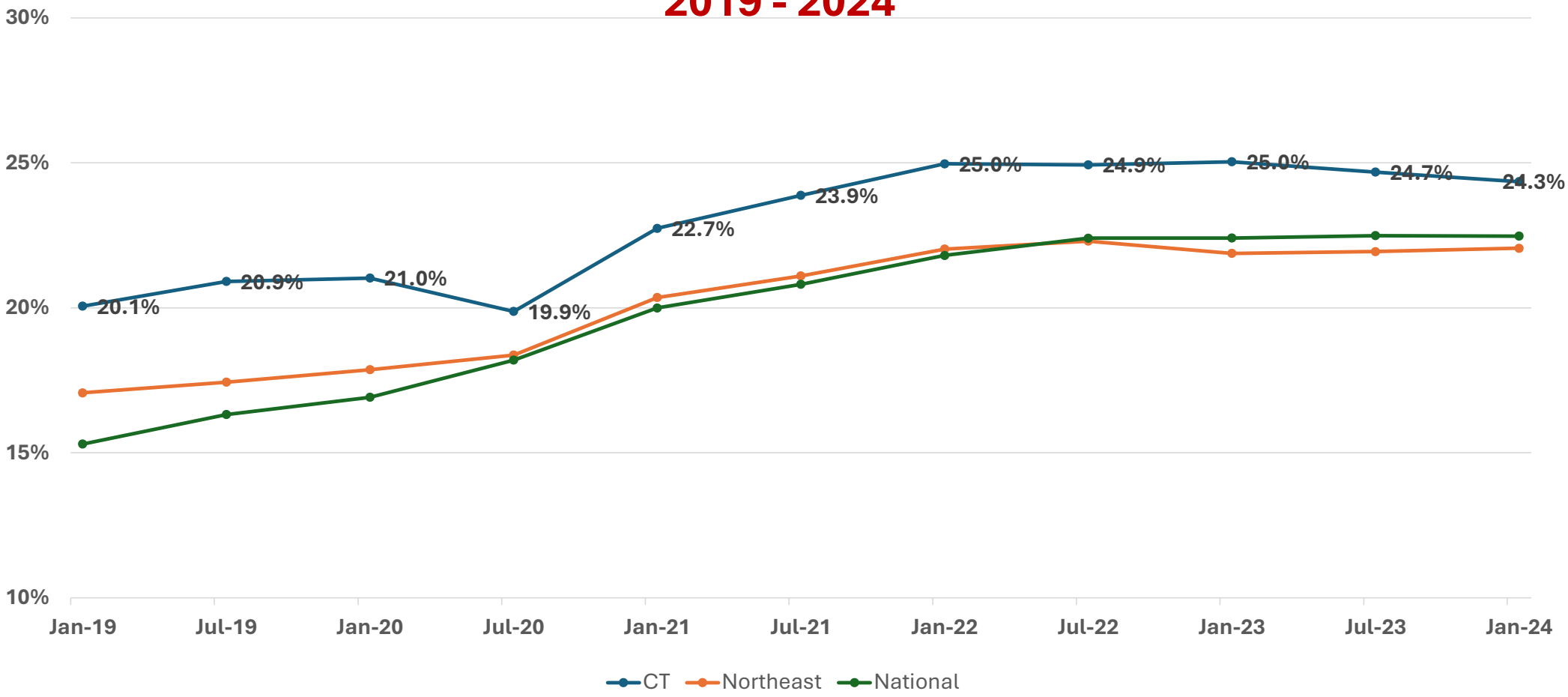
Avalere analysis of IQVIA OneKey database that contains physician and practice location information on hospital/health system ownership

Connecticut Independent Physicians
2019- 2024



Avalere analysis of IQVIA OneKey database that contains physician and practice location information on hospital/health system ownership

Connecticut Physicians Employed By Other Corporate Entities 2019 - 2024



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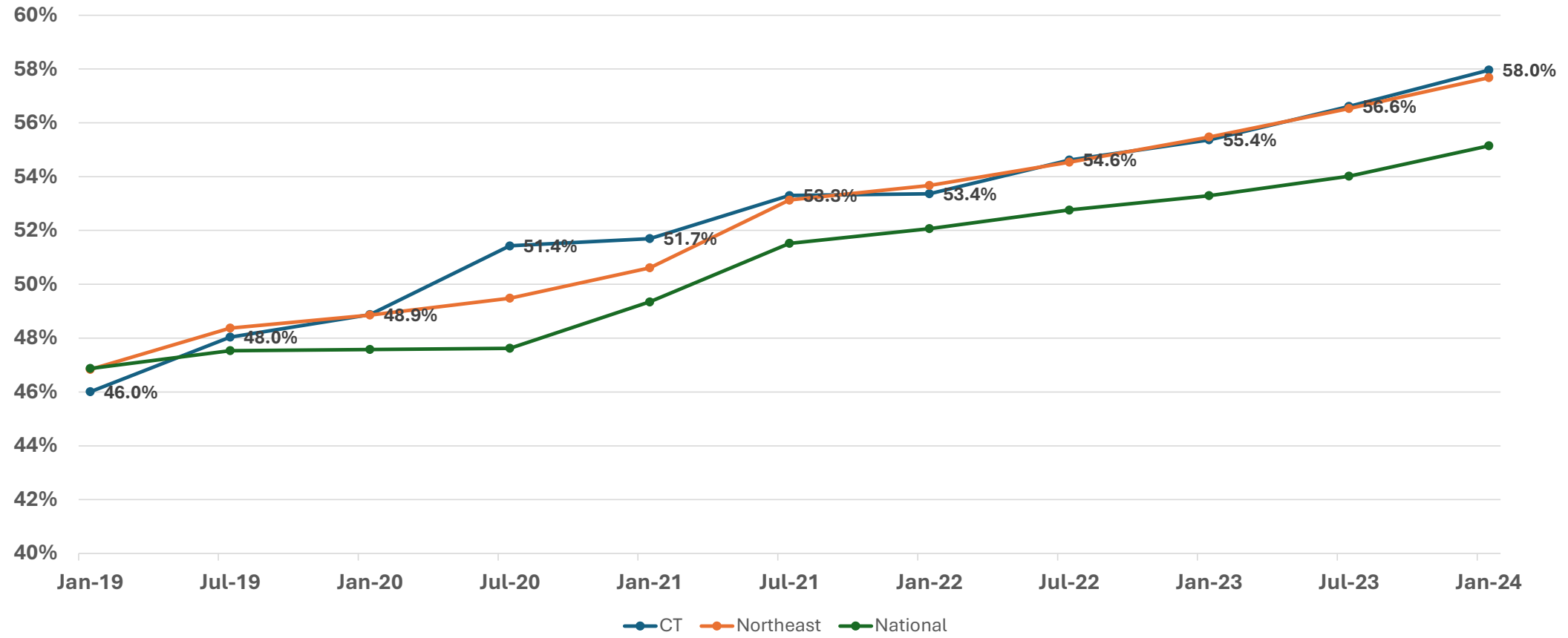
Connecticut Physician Employment
Hospital and Health System
2019 - 2024



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Physician Employment Market Shift

- **Optum:** A subsidiary of UnitedHealth Group, as of last October it reportedly employed 90,000 physicians (20,000 added in 2023) and some estimates now suggest upwards of 100,000 physicians now employed (with the recent proposed purchases of Steward's 1,700 physicians in nine states and a slightly smaller group in Oregon (both needing assistance because of the Change Healthcare issues).
- **CVS/Aetna:** While closing a few dozen minute clinics (25 in the Los Angeles area alone), it purchased Oak Street's 170 primary care clinics and Signify Health's 10,000 clinicians and continues to expand the hiring of physicians and purchasing of clinics, though not at the pace of Optum. It is unclear of the exact number of physicians, but they have stated more than 25,000 clinicians employed (not including pharmacists, though in some markets this is exclusively APRNs and PAs) across its more than 1,100 minute clinics in 36 states. Recently has closed many of those Oak Street locations.
- **Elevance**: Purchase of Paragon Healthcare's 40 ambulatory infusion centers and continues to evaluate purchases through its subsidiary Carelon.
- **Amazon:** A number of changes in approach and design, but continues to employ physicians tied to its more than 220 One Medical brick and mortar offices in 20 markets and some estimates are upwards of 3,000 physicians along with its virtual care company Amazon Clinic that was launched in 2023 but all of these locations have closed as of the end of this summer.
- **Walgreens/VillageMD:** While the news recently is that it has left a number of states (IL, IN, FL, RI, NV) and closed dozens of clinics in those states, it continues to have 680 Walgreens Boots Alliance majority owned clinics (200 co-located within Walgreens and 170 third party clinics in stores) and more than 5,000 physicians, including on large multispecialty group in CT as well as Summit Health-CityMD (30 clinics and 2,800 clinicians). Walgreens has divested from VillageMD as of this summer.
- **Walmart:** Not to be overlooked, has more than 50 clinics in 6 states and estimates of more than 5,000 clinicians (this includes MDs, APRNs, PAs) with plans to open 20 more clinics (adding 2 more states) by the end of 2024 yet this summer suggested it was suspending those plans.
- Private equity backed staffing companies (acquiring more than **100 healthcare staffing** companies between 2020 and 2023) are now involved in more than **60%** of all clinical staffing transactions (Braff Group).
- Almost **390 hospitals** in the US have been acquired by private equity firms.
- A recent study suggests that PE owed physician practices increased from 816 in 2012 to 5,779 in 2021. This same study found these PE firms' market share exceeded 30% in 108 MSA specialty markets (more than 50% in 50 of these markets).
- Federal Government (FTC, DOJ and DHHS) as well as US Senate are now probing private equity backed healthcare deals.

Physician Employment: Physician Perceptions

Pitfall: Allowing changes in practice ownership to ***reduce the quality of patient care***, as well as ***allowing an erosion in clinical autonomy*** and a greater focus on financial incentives. Do not allow a deterioration in relationship with patients, including any decreased visit time and/or communication.

- NORC conducted a survey of **1,000 employed physicians** on behalf of the PAI to gain insights into the implications of this trend on care delivery, clinical decision making, physician practice administration and professional satisfaction.
- For physicians who shifted from independent medical practices, various factors including government and private insurer payment cuts, drove their decisions.

Physician Employment: Care Delivery

Pitfall: Allowing changes in practice ownership to ***reduce the quality of patient care***, as well as ***allowing an erosion in clinical autonomy*** and a greater focus on financial incentives. Do not allow a deterioration in relationship with patients, including any decreased visit time and/or communication.

- Physicians report concerning trends in care delivery, indicating reduced autonomy, strained patient relationships, and diminished communication due to ownership changes
- 58% of physicians reported that reduced autonomy was one of the top negative impacts of ownership changes on patient care quality
- Nearly half of physicians (45%) reported that ownership changes **worsened their relationships with patients**
- **Decreased time and communication** were reported as top negative impacts of ownership changes on the physician-patient relationship

Physician Employment: Clinical Decision Making

Pitfall: Allowing changes in practice ownership to ***reduce the quality of patient care***, as well as ***allowing an erosion in clinical autonomy*** and a greater focus on financial incentives. Do not allow a deterioration in relationship with patients, including any decreased visit time and/or communication.

- Physician responses underscore the complexities involved in making clinical decisions for their patients, including employers' policies that influence these decisions
  - 56% of respondents said that cost of care to the patient has some impact on their clinical decision-making
  - Nearly half (47%) of respondents said that practice policies or incentives frequently led them to adjust treatment options to reduce costs
  - 37% of physicians report moderate or low autonomy in making clinical decisions
  - 61% of respondents have moderate or low autonomy to refer patients outside of their ownership structure/ system
  - 70% of respondents report employer uses incentives for physicians to see more patients

Physician Employment: Administration

Pitfall: Allowing changes in practice ownership to ***reduce the quality of patient care***, as well as ***allowing an erosion in clinical autonomy*** and a greater focus on financial incentives. Do not allow a deterioration in relationship with patients, including any decreased visit time and/or communication.

- Two-thirds of physicians' report having little or no involvement in practice management policies
  - More than 40% of physician respondents expressed dissatisfaction with workforce-related issues including hiring, staff management, and administrative support
  - Respondents expressed high satisfaction with medical equipment, technology training, and the quality of technology/EHR policies and procedures at their current practice
  - Interestingly, more than half (52%) of respondents lacked awareness of a formal process to resolve disputes at their workplace

Physician Employment: Career Path

Pitfall: Allowing changes in practice ownership to ***reduce the quality of patient care***, as well as ***allowing an erosion in clinical autonomy*** and a greater focus on financial incentives. Do not allow a deterioration in relationship with patients, including any decreased visit time and/or communication.

- Physicians who moved from independent practice to employment cited a myriad of factors that influenced their decisions with work-life balance and compensation ranking the highest
  - Government and private insurer reimbursement cuts were driving factors in choosing employed positions for over half of physicians who responded to the survey (53%)
  - 60% of respondents stated that they their current employer required them to sign a non-compete agreement
  - Frustrations with current employment are reflected in the 44% of respondents who said they would join a union if available and amongst the compelling reasons they cite for wanting to retire early – burnout (74%) ranking the highest

Physician Employment: Guardrails

- Key principles for guardrails to protect patients and physicians:
  - Protect against corporate intrusion into the practice of medicine through requirements that physicians retain clinical autonomy and have an appropriate role in key governance, clinical and administrative decisions.
  - Protect against corporate owners' business decisions that threaten the solvency of medical practices, particularly in the case of private equity ownership.
  - Increase regulatory oversight at the acquisition stage.
  - Increase ongoing regulatory oversight to protect against anticompetitive business and practices that undermine patients' access to care and quality of care received.
  - Enhance oversight of transactions related to insurer and other corporate-owned entities.
  - Reform federal physician payment policies that have contributed to consolidation.
  - Modernize federal laws and regulations that create barriers to physician-led delivery initiatives.
  - Work with state policymaking organizations to identify states' roles and necessary policies to counter anticompetitive aspects of consolidation.